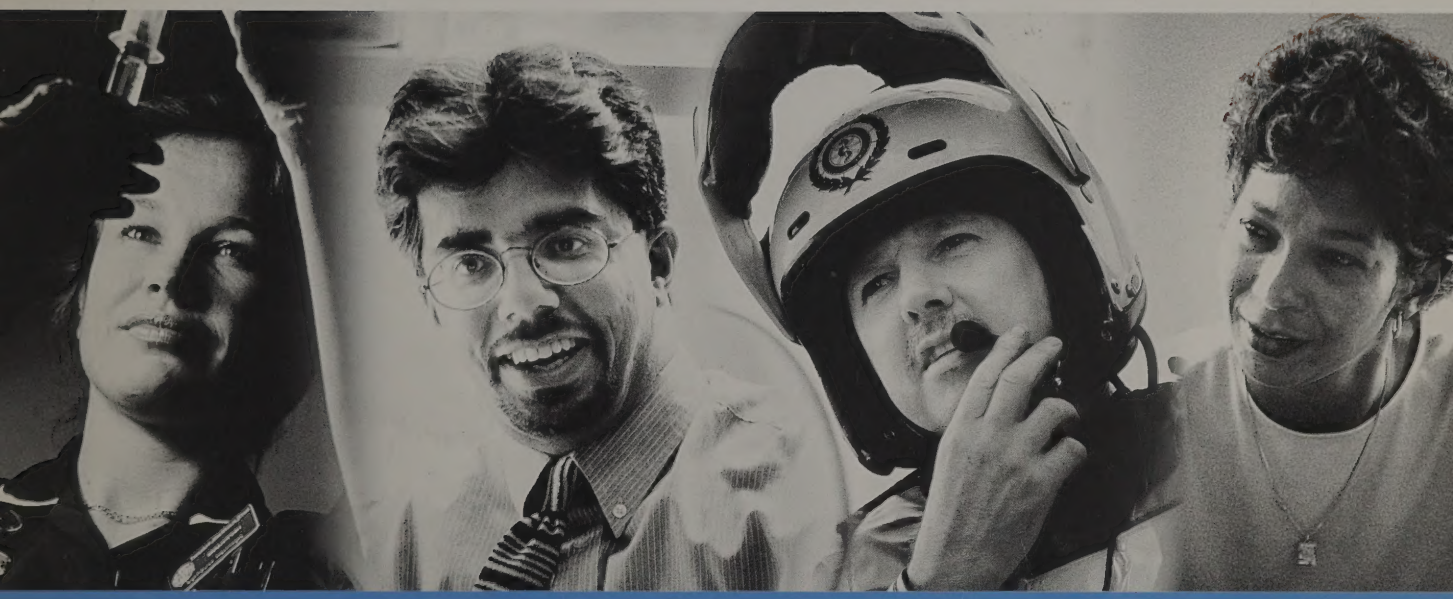
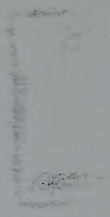
The National Health Service



A Service with Ambitions



The National Health Service

A Service with Ambitions

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

November 1996

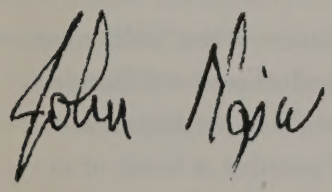
Contents

Opening Statement by the Prime Minister

The National Health Service was established in 1948 to improve and promote health and lift the burden of anxiety about ill-health which so affected previous generations. Since then, despite frequent debate about the development and scope of the NHS, it has proved to be an enduring institution which has earned a special place in our country. It touches all of us and we all have a stake in its future.

This Government is proud of its commitment to the NHS as a public service, promoting health and offering high-quality health care to everyone on the basis of need regardless of the ability to pay – an NHS which is true to its founding principles but which is adapting and developing to meet changing needs and rapid advances in technology and clinical practice.

This White Paper commits the Government to the future development of the NHS in England. It sets a clear direction for the NHS grounded in the needs of individual patients and the development of services. The NHS is part of the fabric of this country, at the heart of every community, and in the hearts and minds of every person. It must continue to be there when we need it.



John Major

Foreword by the Secretary of State for Health

The National Health Service is one of the success stories of modern Britain. Over nearly 50 years it has transformed the delivery of health care, and helped to bring about a dramatic improvement in the quality of care enjoyed by millions of people. It has done so by harnessing the power of modern medicine to reduce and often eliminate the suffering caused by ill-health and disease.

The principles on which the NHS is built command support across the political spectrum and they are endorsed by the overwhelming majority of the British people. They require the NHS to be:

- **universal** in its reach, available to anyone who wishes to use it;
- **high-quality,** applying the latest knowledge and the highest professional standards;
- **available on the basis of clinical need,** without regard for the patient's ability to pay.

The Government is wholeheartedly committed to develop the NHS on the basis of these fundamental principles.

In addition to these principles, which date back to the foundation of the NHS, modern health care has increasingly focused on the *experience* of individual patients. People want to be treated with dignity and respect. They want the right to participate in decisions which affect them. They want to be supported – if possible at home or in their community – by a service which is focused on *their* needs.

This is not new. Generations of clinicians have been dedicated to their patients. Decisions have been brought closer to patients and their carers. But in an increasingly complex and sophisticated service we need to ensure that the patient's interest continues to be the driving force of the whole system.

The Government recognises these changes, and believes that the NHS must also be:

- **responsive,** a service which is sensitive to the needs and wishes of patients and carers.

These four principles represent the foundations on which the future of the NHS must be built. This White Paper sets out our commitment to a developing NHS – "a service with ambitions". It explains what we mean by this and addresses the key issues which will determine how it is to be delivered. It does not foreshadow more management or structural upheaval – indeed it builds on the structures the Government has put in place, to develop the services which the NHS offers its patients.

This is a document about the NHS. But the successful delivery of health care requires us to see the health service in its wider context. The objective of health policy is not simply to deliver health care. It is to improve the health of the nation. This is why the Government set out clear priorities for improving health in its White Paper *The Health of the Nation*.[1] The NHS of the future must reflect those priorities.

Furthermore the delivery of health objectives requires the NHS to work closely with other agencies, both voluntary and statutory. In particular, it will only be possible to secure the fullest benefit from NHS resources against the background of close co-operation with social services.

The Government is committed to providing real increases, year by year, in tax-funded support for the NHS. But the human and financial resources available to the NHS are necessarily limited. It is the task of everybody in the NHS to ensure that patients secure the maximum possible benefit from them. The search for better and more efficient ways to meet the needs of patients must be relentless.

The NHS Research and Development Programme, reinforced by clinical audit and continuing professional education, will play an increasingly important role in this process. It is important that the service which is delivered to patients reflects the latest advances in clinical understanding.

The NHS is working harder than ever before. Front-line staff face real pressures. There are more patients, shorter waiting times, and every year an increase in its capacity to treat and care. The very success of the NHS creates its own demands.

At such a time it is not everyone's first instinct to lift their eyes to the horizon. But the urgent must not be allowed to squeeze out the important. We need a clear idea about how we want the NHS to develop and what steps are necessary to allow that to happen. Ambitious plans cannot be delivered overnight, but their achievement over time requires us to ensure that our day to day decisions are consistent with our longer term objectives. This White Paper formulates those longer term objectives.

Chapter One describes our ambitions for the NHS from the point of view of individual patients and then looks at the implications for specific areas of the service. Taken together, these descriptions illustrate the kind of care we seek from the NHS of the future.

Chapter Two analyses the characteristics of the service described in the case studies and illustrates the service challenges which face NHS management and professional staff.

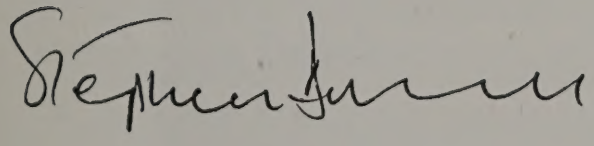
Chapter Three brings together the resource and management implications of NHS care and sets the Government commitment to the principles of the NHS in their broader context.

Chapter Four sets out three new programmes of work I am launching to follow up the commitments made in this White Paper. These adopt the approach taken over the last

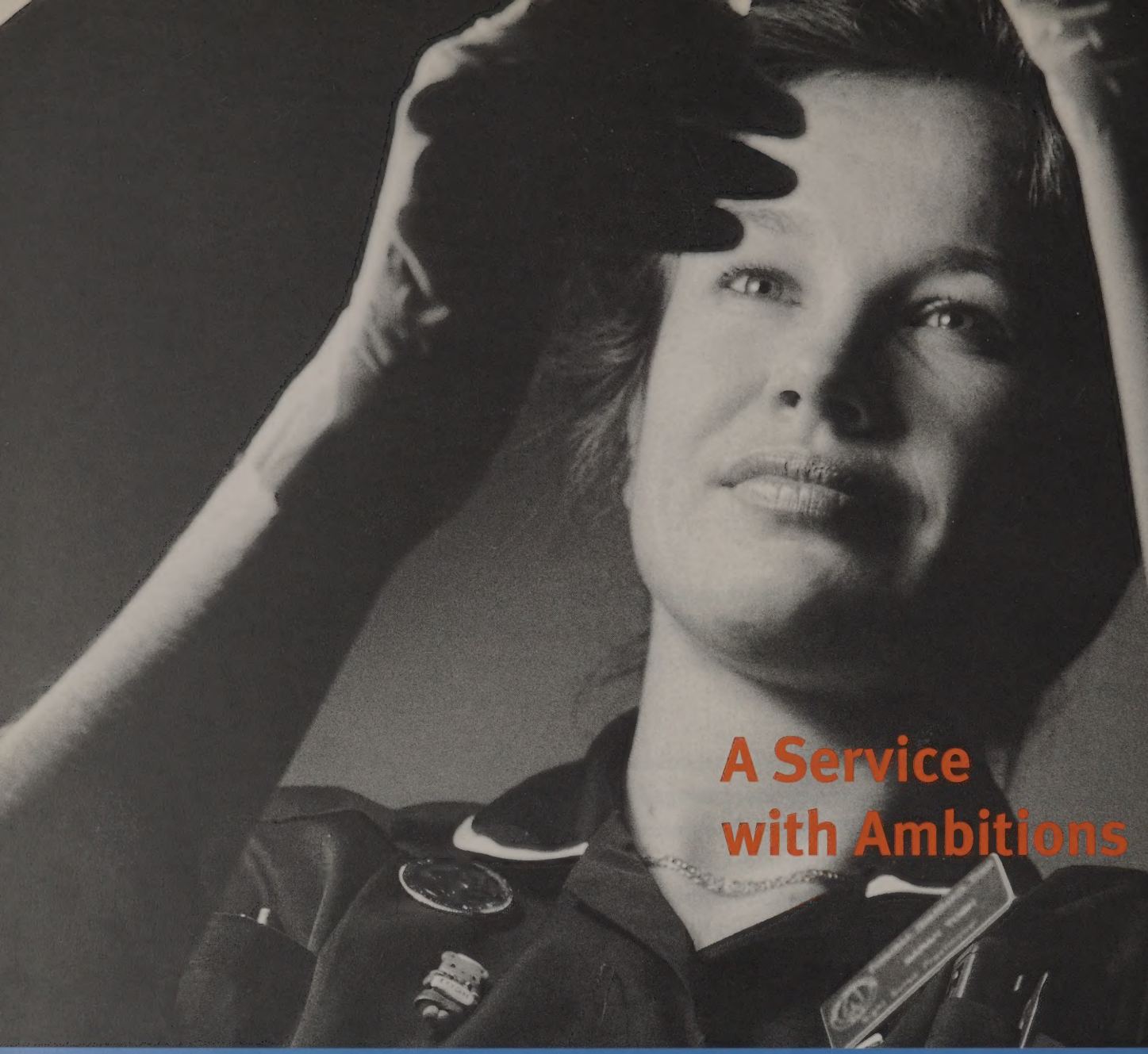
12 months in the development of primary care. That process led to the proposals which the Government announced recently. We now wish to tackle the three issues set out in Chapter Four on a similar basis, inviting the full participation of the NHS and other interests before decisions are taken.

The NHS has experienced a process of substantial change over the last few years, beginning with the management reforms launched by *Working for Patients*.[2] This coincided with the significant developments in health policy introduced by *The Health of the Nation*, the Community Care Reforms, *The Patient's Charter*,[3] the Clinical Effectiveness Initiative and the movement towards a primary care-led NHS. The service has come a long way in a short time.

The ambitions set out in this document do not rely on further radical change. They are rooted firmly in the best of current practice. They articulate the ideas and inspiration of people currently working in the NHS. They reflect the Government's determination to build on the success story which is the National Health Service.



Stephen Dorrell



A Service with Ambitions

The purpose of the NHS is to secure through the resources available the greatest possible improvement to the physical and mental health of the nation by: promoting health, preventing ill-health, diagnosing and treating disease and injury, and caring for those with long term illness and disability who require the services of the NHS.

Our ambition is for a high-quality, integrated health service which is organised and run around the health needs of individual patients, rather than the convenience of the system or institution. An NHS which, where appropriate, brings services to people, balancing, for each individual, the desire to provide care at home or in the local community with the need to provide care which is safe, high-quality and cost-effective.

This is an NHS which offers everyone:

- help to maintain as much independence as possible;
- the security of knowing that health care will be there where and when it is needed;
- the information necessary to understand and take part in decisions about health;
- the care they need without being passed from pillar to post;
- the safest and most effective care and treatment by expert staff.

The illustrations which follow show what this means for individual patients. The implications for specific areas of the service are also considered.

The people in the case studies are fictitious and the description of the care they receive is an ideal. But the studies are based on the best of current practice, the individual elements of which are already available in the NHS. They demonstrate the kind of care which people can expect to receive when we achieve our ambitions for the NHS.

Emergency Care Services

Case Study **Road traffic accident**

Garry Hunter, 22, is trapped inside his car on a rural byroad after he skidded on black ice and hit a stone wall. A nearby farmer calls 999.

The control room identifies this as a top priority, potentially life-threatening emergency and despatches a paramedic to reach the accident as soon as possible, and a fully-equipped ambulance to transport the patient, to follow. Meanwhile, the farmer is given simple, practical advice on what he can do to help the patient before the ambulance reaches him.

By the time the emergency services arrive, the farmer is doing what he can to help Garry and to stem some of the blood loss. The paramedic carries out an initial assessment. Garry has sustained multiple injuries, including to his head and chest, and is unconscious.

While the fire service are cutting Garry free, the paramedic administers oxygen and fluid replacement treatment. She then calls the nearest hospital and discusses the situation with the consultant in A&E. They decide that no further procedures are required before he is taken to hospital.

The paramedic decides the patient is stable enough to travel direct to the hospital, where his condition can be assessed and treated. They are met by a forewarned team of trained staff in anaesthetics, chest surgery and trauma surgery, as well as the A&E consultant involved in the telephone consultation.

The trauma team further assess Garry's condition, and a CT scan is taken and tele-imaged to another hospital, 40 miles away, which has a specialist neurosurgery department. The trauma team establish that the head injury is the most important injury requiring urgent treatment. The consultant neurosurgeon decides that Garry should be transferred for neurosurgery and jointly it is agreed that the patient is fit to travel. Another ambulance, with all the facilities necessary for transfer, is organised to take him there, with an anaesthetist to accompany him. On his arrival, Garry is taken straight to theatre, and after surgery is transferred to the intensive care unit.

"We cover a large and very varied rural area. Four-wheel drive gets us to places traditional ambulances cannot get near."

Ian Ellison, Divisional Commander
Northumbria Ambulance Service

Case Study An irritable child

Debbie Bennet, who is 21, lives alone with her five month old son Jason in a block of flats in a deprived suburb of a large city.

This evening Jason has been tearful and irritable, but after a while has finally settled to sleep. During a telephone conversation later that evening Debbie's mother tells her that the local GP's night surgery was very helpful when she phoned in a few weeks ago about Debbie's father's attack of food poisoning. She encourages Debbie to give them a ring if Jason seems to get worse.

In the early hours of the morning Jason wakes in some distress. Remembering her mother's advice, Debbie decides to phone her GP's surgery and her call is automatically re-routed to the local out-of-hours co-operative.

Sue Carter, the qualified nurse who answers the call, recognises Debbie's anxiety and asks her to outline what has happened. Sue takes Debbie through the questions in the co-operative's new diagnostic support software. Sue advises Debbie to give Jason some infant paracetamol, and says that there is probably nothing to worry about, but that she will have a word with the doctor on duty, and ring Debbie back.

Within ten minutes, Sue calls Debbie back. Jason has calmed down a little, and Sue reassures Debbie that being fractious is common in children of Jason's age and that, although five months is a bit early, he may be beginning to teethe. She tells Debbie to call back during the night if she is at all worried, and she will then arrange for the duty doctor to visit. Debbie is also welcome to visit her own doctor's surgery in the morning. Sue reports what has happened on the co-operative's information system.

In fact, Jason settles down, and seems normal in the morning. When Debbie calls in at her local health centre and reports to the reception desk, the receptionist can see from her computer that she had called during the night. Consequently, she arranges for Debbie to see the practice nurse. The practice nurse confirms that Jason is fine, and gives Debbie a booklet produced by the health authority and local primary care professionals, giving advice on common symptoms (including teething) in young children.

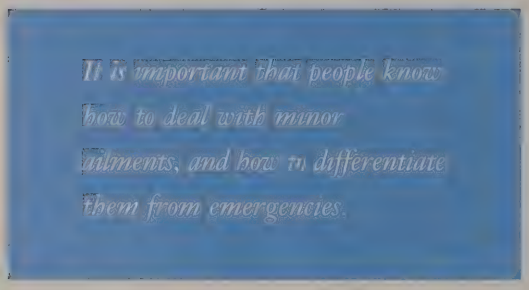
"It's reassuring for callers to know that when the surgery is closed they still have immediate access to a doctor and full back up of the primary care centre."

John Charters, General Practitioner
Northern Doctors Urgent Care, Ashington

Emergency Care Services

Currently, there are an increasing number of services available 24 hours a day to support people with needs that have suddenly arisen and require immediate attention. All emergency ambulance services, and the vast majority of A&E departments and GPs, have always been available on this basis. Other services such as pharmacies, social services teams, community psychiatric teams, nurse practitioners and telephone advice increasingly provide 24 hour cover.

For those with minor conditions (like Jason Bennet), access to advice and information is worthwhile so that people can judge whether they can deal with the condition themselves. It is important that people know how to deal with minor ailments, and how to differentiate them from emergencies. This support may be from health leaflets and literature, the local pharmacist, or by means of telephone helplines. The role of 24 hour primary care in supporting the needs of these people is central.



Some patients living at home may be assessed by a GP as needing hospital support as soon as possible, and arrangements made for admission directly to a hospital bed. This may require a period of observation in hospital, perhaps in an assessment unit. Early discharge may require appropriate community support, and liaison with the primary care team.

Those with severe and life-threatening needs (like Garry Hunter) will need speedy access to a team of well-trained professionals whether at the scene of the incident or in hospital. The NHS has a key responsibility in organising high-quality emergency care services that integrate community-based services with a hospital's ability to care for those who are critically ill.

Both the patients and the general public in the two case studies were well-informed about the services available to them and how to access them. The farmer and Debbie were both confident that they could reach emergency services 24 hours a day.

In the case studies, it was clear to the health professionals that they were operating within a system which positively helped them to make their contribution most effectively for the benefit of their patients. Standards and working procedures had been agreed in advance; expert sources of knowledge were readily available to them and they had had access to the latest training; an efficient communications infrastructure within and between hospitals and health services meant that staff were forewarned and well-prepared to manage situations at speed and under pressure.

Joint training, easy re-routing of telephone calls between agencies, co-location of different services such as community psychiatric nurses and social workers in A&E departments can all help professional staff work together on a multi-professional basis.

General Health Services

Case Study **A hip replacement**

Violet Harrison, 76, lives alone in a second floor housing association flat in a small market town. She has had osteoarthritis in her right hip for some time, but over the past few months she has developed increasing stiffness and pain. Mrs Harrison's GP refers her to an orthopaedic outpatient clinic due to be held in a few weeks' time at the town's community hospital.

When she sees the orthopaedic surgeon, Mrs Harrison is informed that a hip replacement is one option to restore her mobility and relieve her pain. The surgeon outlines the benefits and difficulties of this procedure, and Mrs Harrison spends some time talking with the specialist clinic nurse about the operation. They discuss what sort of care Mrs Harrison can expect whilst in hospital and at home. The nurse plays a short video for Mrs Harrison, who decides to opt for an operation and is booked onto the waiting list. The operation will be carried out at the large general hospital 20 miles away.

Mrs Harrison also sees the occupational therapist to discuss what can be done to help her cope with daily living activities until her operation takes place. The occupational therapist provides her with simple aids to help with dressing, using the toilet, getting in and out of bed and rising from her armchair safely. Since Mrs Harrison is also having difficulty climbing the stairs, the occupational therapist contacts the housing association who agree to arrange for extra stair rails to be fitted. This equipment will also help Mrs Harrison during her period of recovery.

Mrs Harrison's date of admission is notified three months in advance. During that time she undergoes a number of tests at the orthopaedic clinic, and a complete medical history is taken. A couple of days before being admitted to hospital, Mrs Harrison is assessed by the anaesthetist.

Three days after her operation, Mrs Harrison is transferred to the community hospital, where she remains for two weeks, receiving physiotherapy and occupational therapy to support her rehabilitation. The district nurse, who works closely with Mrs Harrison's GP, visits her before her discharge and agrees with her the nursing services she will need on return to her flat. Mrs Harrison's care manager co-ordinates a package of care to follow her discharge, and ensures that Mrs Harrison has a copy of the care plan. Back in her flat, the district nurse visits her, as agreed, and her GP also looks in to check on her progress.

"Mrs Allen comes in for respite care a few times a year. She knows she will be among familiar people so it alleviates her anxiety. That's the real benefit of a community hospital."

Jo King, Professional Nurse Adviser
Buckingham Community Hospital

General Health Services

Case Study **Insulin-dependent diabetes**

Ahmed Ali has just started school. One day his teacher notices that Ahmed is drinking a lot of water and visiting the toilet frequently. He asks Ahmed's father if this is normal for him. His father thinks this is unusual. Ahmed is still very thirsty by the time his mother gets home from work. She is concerned enough to make an appointment to see their GP.

At the local surgery, the GP takes a brief history and then tests Ahmed's urine – and finds sugar, a possible indication of diabetes. Ahmed's parents are initially upset and confused about what this means: she tries to allay their fears, and asks the diabetes specialist nurse to spend some more time with Ahmed's parents to explain the situation more fully.

The family is referred to the local children's unit as a matter of urgency that day, where Ahmed is admitted immediately. Following some further tests, a diagnosis of diabetes is confirmed, and hospital treatment to stabilise the condition is begun.

Over the next couple of days the hospital doctors, nurses, the pharmacist and the dietitian spend time explaining and helping Ahmed's parents, through a link worker, to understand what diabetes means and how it can be controlled. Ahmed is given his first insulin injection on the ward. Before he is discharged, Ahmed's parents are given advice on how to test blood and urine; how to draw up and inject insulin; on symptoms; what to do if his condition deteriorates; and when Ahmed should be taken to hospital. Ahmed's long term care is to be managed jointly by the hospital and by his GP, with whom the hospital liaises on his discharge. The GP makes arrangements for Ahmed to be seen by her team, particularly the diabetes specialist nurse, on a regular basis. Initially he will also be seen at monthly intervals by the hospital team, who have also agreed to undertake Ahmed's annual medical check.

The diabetes specialist nurse meets Ahmed and his parents after he leaves hospital. She will give Ahmed his next few insulin injections, and she talks to his parents about the regular diabetic clinic within the practice and about organisations which can offer advice and support.

Within four days Ahmed returns to school. The specialist nurse liaises with the school nurse about Ahmed's treatment and self-care programme, and attends a lunchtime meeting for the teaching staff to explain how they can help Ahmed lead as independent a life as possible.

"Working as a community nurse in a GP surgery means patients see the same person every time in a familiar setting."

Mary Matthias, Nurse Practitioner
Streatham Hill Primary Health Care Centre, Lambeth

Case Study Intermittent chest pain

Julie Robertson, 55, was recently made redundant from her job in a local factory. Julie smokes 20 cigarettes a day. While walking the dog today, she feels slightly short of breath. In the early afternoon, whilst going upstairs at home, Julie experiences some slight tightness in her chest.

Julie mentions this to her 17 year old daughter when she returns from school. Her daughter suggests that her mother phones the local health helpline for advice. Julie does this, and after describing her symptoms, she is asked a number of questions. The helpline operator suggests that the best way forward is to re-route Julie's call to her GP surgery. Julie's GP advises her to come to the health centre that afternoon for an appointment with the practice nurse, who will do some tests before she sees one of the practice doctors at 5.30pm. The details are arranged by the health centre receptionist.

When Julie sees her doctor, he says that her heart trace and other tests appear fine, but that he would like her to attend the cardiac clinic at the local hospital the following morning. Julie agrees and he books a late morning appointment through his computer link.

When Julie arrives at the hospital, the staff have arranged more tests for her. When walking on the treadmill she gets further tightness in her chest.

The following day Julie returns to her GP. He tells her that the ECG traces taken yesterday indicate that she has mild angina, and together they discuss a management plan. She is advised to exercise on a regular basis, to stop smoking, to cut down on her intake of saturated fats, and to take a small dose of soluble aspirin daily. She is also given a supply of glyceryl nitrate to put under her tongue if and when she gets further tightness in the chest. Her doctor prints out some tailored information sheets for her.
The surgery receptionist arranges two appointments for Julie: the first with the practice nurse, who has been trained to give support to patients who want to stop smoking; the second is for a clinic, which the cardiologist will be carrying out at the practice next month.

"I was always keen to go into general practice. I like the autonomy, variety and most of all the continuity of care it offers."

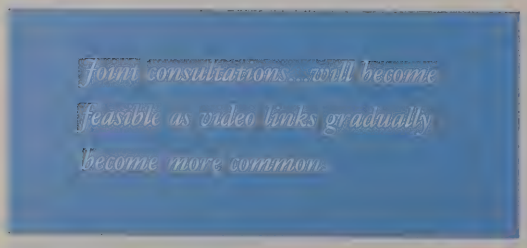
Dr Arvind Madan, General Practitioner
Hurley Clinic, Kennington

General Health Services

The NHS has an important role in promoting health and preventing ill-health. Working in partnership with organisations, communities, and individuals, the NHS helps people to understand and influence their own health. Much of the responsibility lies with primary care, through pharmacists, dentists, optometrists, nurses and health visitors, as well as GPs. Screening, immunisation, vaccination, contraceptive advice, health education and access to information are all vital to the general health of the population.

Most patients begin their journey into the NHS in primary care, perhaps seeking advice from a pharmacist, GP or health visitor. Knowing when and where to go for help, and being able to recognise worrying signs and symptoms earlier, can help reduce anxiety in patients and lead to more effective use of the health services. This underlines the importance of effective health education, and well-organised public information on health, illness, symptoms and treatment.

Within the primary health care team the GP has the prime responsibility for assessment and diagnosis. These clinical skills can be supported by information systems which help with the recognition of more unusual conditions. The primary health care team will need evidence-based information to guide the development of treatment plans.



In many cases, GPs may still need advice from a consultant specialist on diagnosis or on treatment, but that should not always mean that the patient has to travel to see the consultant. Joint consultations between GPs, their patients and specialists will become feasible as video links gradually become more common.

In some cases particular procedures or specialised resources will be needed, and the patient will need to be referred to hospital, which for some conditions could be a specialist centre. Sometimes treatment plans will need to involve several different specialties and health professionals. The emphasis will be on getting the patient back into his or her normal home environment as quickly as possible once hospital-based treatment has been completed. Continuing support may then be from the primary health care team, or jointly with a secondary care specialist team. The ability to use developing technology to transfer relevant information quickly between professionals will be particularly important.

In the three case studies, care was co-ordinated from start to finish by the primary health care teams. This reduced the extent to which the patients had to move around the system, but still ensured that specialist hospital treatment could be provided when needed. Having care co-ordinated close to home meant that patients could be treated in their normal environment – in Ahmed's case, his school teachers helped to support the management of his condition.

There will not always be a smooth passage through assessment, diagnosis, treatment and care. A patient with a long term condition may have a sudden crisis. The principles are very similar: overall co-ordination of care usually provided by the primary health care team; referral for specialist treatment if the crisis cannot be managed in primary care; continuing support in the home environment once the crisis has been resolved.

Patients may have minor ailments and injuries which are short-lived, or they may require a discrete procedure. However, the majority of resources in the NHS are needed for people whose condition is longer-term. Many will have chronic illnesses, some emerging early in life, the majority developing in older age. Even where it may be possible to get patients back into good health, they may require rehabilitation over a long period of time. In these cases, the continuity of relationship with the primary health care team, and the co-ordination of care and support from different agencies will be particularly important.

> *The emphasis will be on getting the patient back into his or her normal home environment as quickly as possible...*

Recent developments in maternity services, through the implementation of *Changing Childbirth*,[4] and in cancer services, following publication of *A Policy Framework for Commissioning Cancer Services*,[5] reflect the principles of good practice outlined here. These provide a model which could be extended to other service areas.

Services for People with Special Needs

Case Study **Severe mental illness**

Edward Connolly is a 23 year old who was diagnosed two years ago as having schizophrenia. Before becoming ill, Ed was training to be a chef – now he is unemployed.

After a recent episode of illness, and following a multi-professional assessment, which included representatives from the local housing authority and the inner city community mental health team, a place was found for Ed in a supported hostel.

This afternoon the duty manager at the hostel notices that Ed's behaviour is becoming abusive and uncontrolled. She quickly checks the hostel's information system for any record of similar behaviour and is concerned that there are echoes of a situation four months earlier when Ed smashed up his room and lacerated his arm.

She rings the community mental health team and Tony Moffat, the duty mental health nurse, comes out within the hour to see Ed. While talking things through, Tony suspects that Ed may have missed a dose of medication earlier that day, but Ed tells him that he has been upset by an argument with another client at the day centre which he attends. Tony discusses the situation with the duty psychiatrist over the telephone and they agree that Tony should remain with Ed and try to help him cope with his angry feelings, before any further action, such as altering Ed's medication or possibly arranging for his admission to hospital, should be considered.

Tony and Ed talk about what has happened at the day centre, and over the next hour or so Ed becomes calmer and any changes to medication or admission to hospital are no longer considered necessary. Before leaving the hostel, Tony sits down with the duty manager and records these events on the hostel's information system, which is linked to the local health and social services integrated mental health case recording system. (As part of the care planning process, Ed had given his consent to information about him being shared with other professionals in the community mental health team.)

"Working with colleagues from a range of professional backgrounds we encourage our residents to get involved in group activities which give them a real sense of achievement."

Christina Whittaker, Senior Occupational Therapist
Woodlands House, Aylesbury

Case Study **Learning disability**

Melanie Wishart is 20 years old and about to leave home to embark on a more independent life. She has a moderate learning disability and occasionally displays challenging behaviour. She also frequently suffers from minor illnesses, and has epilepsy. She is moving to a supported house in a nearby town which she will share with three other people of her own age, with learning disabilities. Moving away means that Melanie will be able to attend a College of Further Education.

Education and social services staff have worked with Melanie and her parents, while Melanie was still at school, on a transition plan to support her move to the FE college. Melanie's care manager is Joanne Simpson, a social worker who specialises in learning disability. Joanne was involved with the transition plan, and her main task has been to help in assessing Melanie's needs and to put together a package of residential and day care, funded jointly by the health authority and local authority, to meet those needs. This has involved a housing association, voluntary organisations, health care and education providers, and a variety of social services colleagues, both within and outside the learning disability services.

This task has been made easier by the fact that Joanne already knows many of the people involved, having met them on one of the regular joint training events organised locally. Joanne is also working closely with one of the learning disability community nurses in order to ensure that Melanie will have access to appropriate primary and specialist health care, and that Melanie's health care needs will be met promptly and sensitively by the local GP, the primary health care team, and specialist community services.

Joanne's efforts in assembling these different contributions to Melanie's care have proved worthwhile. Melanie copes well in her new surroundings, her epilepsy is well-controlled, and she enjoys her college course.

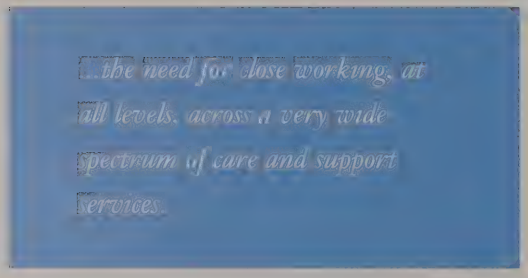
"The most important skill is listening. By responding to what an individual wants we are helping to bring that person's life alive."

Andy Bradley, Centre Manager
Middle Hill Resource and Activity Centre, Worthing

Services for People with Special Needs

The term "special needs" is used to cover a range of client groups, including people with mental illness, learning disability and physical and sensory disability. Each of these has different and particular needs, although all services for these groups have some common aims.

A particular feature of such services is the need for close working, at all levels, across a very wide spectrum of care and support services. The patients in these two case studies had the benefit of receiving care and support from a group of professionals drawn from education, social services, housing and voluntary organisations. These professional staff had access to an effective communications system which allowed them to share information quickly and accurately. In addition they were all working to a carefully considered package of care, tailor-made for the individual.



As a matter of good practice, sharing relevant information is vital if multi-professional and inter-agency care is to function effectively. At the same time, people with special needs are entitled to the same confidential handling of information about their health or social care as any other patient.

Better evidence-based information about illnesses and disabilities and understanding of the range of services available is needed to allow individuals and their carers to take an active part in the design of care plans, and to help professionals co-ordinate the best package of care.

Organisational and professional boundaries should be of no consequence to users and carers; multi-professional and multi-agency education, training and development can support this aim. It is vital that staff work closely with individuals and their families or carers.

Services for people with a mental illness will be largely provided for people at home with the support of locally-based health and social services staff based in local communities. People with severe mental illness should have help at hand around the clock from specialist teams, with an emphasis on preserving their ability to lead as independent a life as possible and on pre-empting crises. Should a crisis develop, and admission to hospital prove necessary, a patient's key worker and community mental health team should provide continuing contact and support during the hospital stay and immediately following discharge.

People with less serious mental illnesses are likely to be more confident about approaching services for help, if they are more knowledgeable about mental illness and clearer about the sorts of services open to them.

The vast majority of people with a learning disability are already living in normal accommodation in local communities. The NHS is continuing to develop appropriate community-based services to replace the remaining old long-stay hospitals and other

institutional settings. Community-based health care teams should be providing a range of specialist health care for specific needs (for example, challenging behaviour) in close partnership with the wider caring team providing housing, educational, leisure and other types of social support.

There should be ready access to primary care and to general and specialist hospital services for people with a learning disability when necessary. Staff working in these services should have an increased understanding of the needs of all those with special needs, including learning disabled people.

The NHS and its partners should give increasing priority both to the prevention of physical and sensory disability, and to the problems associated with disability where it has been diagnosed. At the point of diagnosis people should be informed honestly, sensitively and fully of the nature and consequences of the disease and given access immediately to counselling, advice and support. The NHS should be leading the way in changing public attitudes towards disabled people.

It is vital that staff work closely with individuals and their families or carers.

Services for Older People

Case Study **Stroke**

At the age of 78 George Ramsay has a major stroke. His GP admits him directly to the local general hospital. He is found to have high blood pressure and a CT scan shows that he has had some bleeding into his brain.

Following treatment, his condition stabilises and he moves to the Stroke Unit for rehabilitation, which is continued after three weeks in a nursing home. During his time in the Stroke Unit, Mr Ramsay is invited and agrees to participate in a research study to evaluate different rehabilitative settings.

Mrs Ramsay is keen to have her husband home. After the hospital-based social worker is contacted by Mr Ramsay's named nurse, a community care assessment is carried out by a multi-professional team to determine what support Mr Ramsay might require on discharge, and whether Mrs Ramsay will be able to cope with looking after him at home.

A care plan is agreed by both health and social services, and includes input from the local community rehabilitation team. The physiotherapist and the speech and language therapist work with the family at home and give ongoing support through their trained assistants, in conjunction with the social services occupational therapist. The district nurse attached to the local GP practice acts as key worker (in partnership with the social services care manager), and visits weekly.

After five months, Mr Ramsay has a further severe stroke, and is readmitted to hospital. When asked, Mrs Ramsay says she has begun to find it difficult to manage, and feels anxious about caring for him if he is even more dependent.

A multi-professional assessment (led by social services) finds that Mr Ramsay meets the criteria for a social services-arranged nursing home. After talking it through with the hospital-based social worker, Mrs Ramsay chooses a nursing home which is easy for her to visit, and which provides the sort of the food he likes. The nurses there plan Mr Ramsay's care with help from his wife, and using information from all the professionals previously involved.

Four months later Mr Ramsay contracts pneumonia, which he, his wife and his GP had previously agreed not to treat with antibiotics. Mrs Ramsay is beside him when he dies.

"Given the choice, most of us would prefer to be in our own homes. We work with the client and the carer to make it happen."

Lorraine Kendall, Occupational Therapist
Arundel Community Rehabilitation Team, Chichester

Case Study Alzheimer's disease

Bert Williams is 74, a widower with steadily progressive Alzheimer's disease diagnosed four years ago. He has one son, who is working on a long term contract in the Middle East.

Mr Williams has a care plan which was initially developed after a multi-professional assessment at home two years ago. Nick Cunningham is the named care manager responsible for Mr Williams' care; he is employed by social services and attached to the local GP practice. He put together a care plan for Mr Williams, which has been regularly reviewed. The care plan included day hospital attendance for three days each week, and personal care arranged by social services, who charged him for services according to his ability to pay. Nick had assisted Mr Williams, with long-distance advice from his son, with making arrangements for his finances, such as his will, and taking out an enduring power of attorney. He also put Mr Williams in touch with the local Alzheimer's Disease Society, who gave him invaluable information, advice and personal support.

More recently, neighbours have expressed concern that Mr Williams has begun to wander at night, and that he looks increasingly unwell and unkempt. The specialist old age psychiatry services assist Nick and the primary care team with the reassessment of Mr Williams' needs. The care plan is reviewed to include night sitting services, extra personal care, and increased attendance at the day hospital. Medication in the evenings to reduce his wandering is considered, but it is difficult to be sure that Mr Williams will take it, and he is already a little unsteady on his feet.

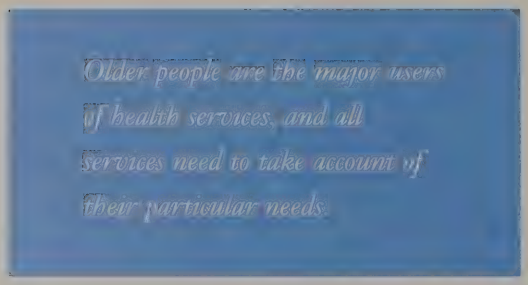
Mr Williams' dementia leads to greater changes in his behaviour and eventually reaches a stage where he needs 24 hour care. Following an assessment in hospital, Mr Williams accepts a place in a small nursing home funded by the NHS, which is registered to meet the needs of older people with mental health problems. The staff are caring and enthusiastic, and they work with the old age psychiatry and social work services to establish a care plan to meet his needs. When Mr Williams' son returns on a visit from the Middle East, he is relieved to find his father settled and well cared for, and regularly visited by friends in the neighbourhood.

"Support must meet needs and maximise strengths. Losing your health should never mean losing your dignity."

Madeline Armstrong, Project Co-ordinator
One Stop Dementia Care Project, Greenwich

Services for Older People

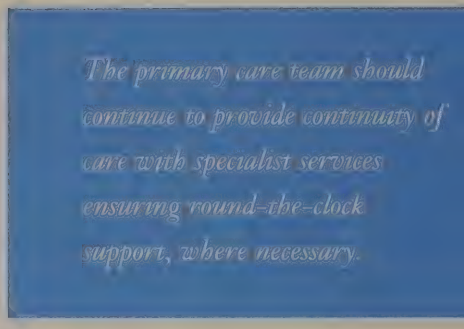
Older people are the major users of health services, and all services need to take account of their particular needs. Primary care is the focus for care delivery and care co-ordination. The extended primary health care team, including therapists and community pharmacists, working with the local social services team, should ensure timely assessment and diagnosis, and access to appropriate services.



The primary health care team should concentrate on maintaining mental and physical health, with health promotion programmes for "the younger older group", helping older people remain healthy and active through retirement. Particular attention needs to be given to the early signs of mobility problems, to falls, to incontinence, to confusion, to difficulties with taking medicines, to depression, and to deterioration in sight or hearing. With an increasing range of effective treatments, early action is of paramount importance.

The social services department has a responsibility to assess the needs of vulnerable older people and where necessary, to arrange a care package which is regularly monitored and reviewed by a care manager, taking account of the needs and role of any carers. The information could be held on a practice continuing care register.

Patients may be referred, perhaps using local guidelines, to specialist services for more complex assessments, for an expert opinion, or for an episode of care. The advantages and disadvantages of any treatment should be discussed with each patient before decisions are made jointly. The primary care team should continue to provide continuity of care with specialist services ensuring round-the-clock support, where necessary.

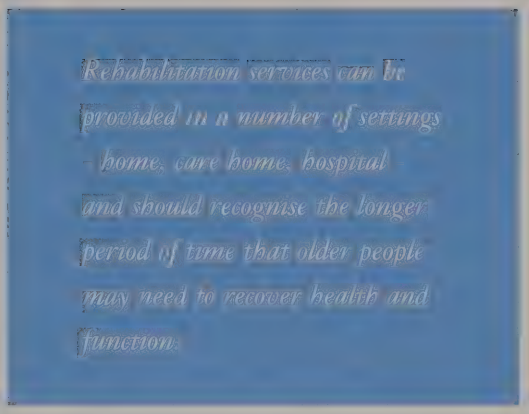


Increasingly in the acute sector, ambulatory care and day patient care will become the norm. Pre-treatment assessment will assess the needs of older people for additional support – for example, an overnight stay after surgery, a period of nursing home care after leaving hospital, or home care after discharge.

Rehabilitation services can be provided in a number of settings – home, care home, hospital – and should recognise the longer period of time that older people may need to recover health and function.

Where older patients seem likely to need continuing care, perhaps involving a move into a nursing home or a residential care home, the relevant hospital and community health staff will be involved with social services in carrying out a multi-professional assessment of the person's needs.

"Young retired" people already contribute as informal carers, and should also be influential in shaping the development of all services which meet the needs of older people. Primary care teams, NHS Trusts and purchasers should all involve representatives of the older community in decision-making and in advocacy schemes.



Realising the Ambition: Objectives

Our ambition is for a high-quality, integrated health service which is organised and run around the health needs of individual patients, rather than the convenience of the system or institution. An NHS which, where appropriate, brings services to people, balancing, for each individual, the desire to provide care at home or in the local community with the need to provide care which is safe, high-quality and cost-effective.

The case studies describe what "a service with ambitions" would look like. The challenge is to make this happen everywhere. Some clear strategic objectives emerge from the case and service studies; achieving these objectives requires sustained and co-ordinated effort by policy makers, managers and clinicians in the NHS and its partners in other agencies.

A Well-informed Public

A service responsive to the needs and wishes of patients is one where patients are fully involved in their health and health care. Knowledge about health, illness, symptoms and treatment gives people more control over their circumstances, and helps them access and use services effectively. People need good quality information:

- on how to stay healthy and choose healthy options;
- when symptoms appear or in an emergency, to know what actions to take to help themselves, and whether, when and how to seek help;
- if a condition is diagnosed, to understand the implications and to take part in decisions about treatment and care.

Many organisations and individuals play a part in providing this information, including Government, the media, voluntary groups, social services and schools, telephone health information services, and those working in the NHS. Co-ordinated action is required at both national and local level to ensure a well-informed public.

"The service makes it easy for callers to get the information they need to help them take an active role in their health and well-being."

Fiona Stobie, Health Information Service Manager
Winchester

A Seamless Service

Many agencies are involved in promoting health and caring for people. A seamless service is one where services which individuals need are co-ordinated and integrated across the health and social care system, including primary care and social care. In a seamless service:

- organisational boundaries do not get in the way of care for patients, but it is clear who is responsible and accountable for their care at all times;
- the planning and contracting process supports practical working arrangements;
- roles and responsibilities are clearly defined;
- multi-professional teams come together to provide high-quality services for patients, that make the best use of the specialist skills and experience of the staff involved;
- all staff are trained to work in multi-professional teams, and there is support in working across organisational boundaries.

Working across the boundaries of health, social care and voluntary organisations can be challenging; different funding regimes, different priorities, different boundaries, and different organisational cultures all contribute to this. Good working relationships, shared information, an understanding of other perspectives and a common commitment to the interest of patients and clients can all help overcome the difficulties.

"The Centre shows how GP-led primary care can work closely with dentistry, chiropody and other community services to meet local health needs."

Jude Bowler, Centre Manager
Riverside Centre for Health, Toxteth

Developing an integrated NHS also depends on effective partnerships across the boundary of primary and secondary care. Of course, the same principles apply. As changing practice allows more treatment and care to be carried out in the home or local community, the role of secondary care professionals will continue to evolve. They will remain specialist practitioners, drawing on the body of expert knowledge and skills, and making use of the range of services located together to deliver care to patients in a complementary way. They will work together with the primary health care

team, ensuring that patients receive integrated care that draws the best from both sectors. There will also be an increasingly important role for professionals in secondary and tertiary care, using their specialist knowledge and experience, as a resource for primary care professionals so that through everyday contacts, and co-operation in joint audits and guideline development, all will be able to benefit from the latest research and therapeutic practice.

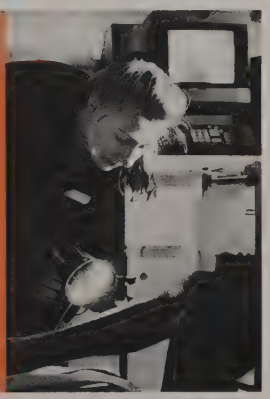
Developments in communications and information technology will have an important role, both within the NHS and between the NHS and its partners, so that the necessary information about patients and their care, and about the organisation of services, is readily accessible to those who need it. The systems to do this need to give patients and their carers confidence that this information will not be available to those who have no right to see it.

"The video link is technology working for the patient. It gives me quick and easy access to a specialist opinion when I need it."

Angela Burton, Nurse Practitioner, Parsons Green Centre, Fulham

"I don't want to go to a large hospital. This is so easy and quick it could have been built just for me."

Una Reffell, Patient, Parsons Green Centre, Fulham



Knowledge-based Decision-making

A service with ambitions is one that invests in the future NHS through research and development, and which ensures that the most effective practice is used throughout the NHS. To achieve this the NHS needs:

- to be part of "frontier" scientific research, working with colleagues elsewhere in the world to improve understanding of the causes and effects of disease, and to enable improvements in the prevention, diagnosis and treatment of serious causes of death and disability;
- to be involved in evaluating and assessing both new technologies and existing practice, getting up to date information to practitioners on developments and changes in their field;
- to work with the health care professions to ensure that professionals in all disciplines routinely review their performance and are able to bring the most effective practice into general use.

Current developments in information and communications technology will make information ever more accessible to practitioners – through on-line protocols and decision support systems, and with access to specialist opinion and advice. Continued action is required, through the Research and Development Programme and the Clinical Effectiveness Initiative, to achieve this objective.

A Highly Trained and Skilled Workforce

Ultimately it is the skills, knowledge and attitudes of staff which determine the patient's experience of the NHS. A commitment to continuous education and learning ensures that these attitudes and the values which underpin them are updated as they are passed on from one generation to the next.

The professional basis of the NHS workforce is one of its strengths. The combination of professional self-regulation and public accountability ensures that the professions are committed to the health and well-being of their patients, and to the development of the NHS as a whole. The statutory and regulatory bodies, the universities and the Royal Colleges have a crucial role in education and training and improving standards of practice.

The NHS is the biggest employer of diploma and graduate students in the country and maintains a strong tradition of working in partnership with universities and other academic bodies. NHS employers – principally health authorities and NHS Trusts – have a key role to play in supporting this partnership and in providing direct training and development opportunities for all staff throughout their working lives.

"Working in the practice enables me to contribute my specialist knowledge as a pharmacist to the clinical expertise of the GP for the benefit of the patient."

Peter Richards, Community Pharmacist
Lincoln

The delivery of high-quality, responsive patient services relies not only on effective clinical skills but also on a wider range of competencies, including the ability:

- to see and understand things from the perspective of the patient or carer, and to be an effective communicator;
- to understand and make the most of the whole health and social care system;

- to work in teams, even where they cross organisational boundaries;
- to identify health needs and understand the opportunities for health promotion as well as treatment and care;
- to work with patients and carers, ensuring that they can play a part in decisions and choices affecting their treatment or care.

Achieving these objectives requires a co-ordinated approach from a number of different bodies. Centrally, the NHS allocates £1.7bn each year to support professional education and training, in addition to the funds invested locally by health authorities and NHS Trusts, and it is essential that this money is directed to support the ambition for the future.

A Responsive Service

The ambition of a high-quality, integrated service that is sensitive to the needs and wishes of patients applies to the whole of the NHS. This does not mean, however, that identical service patterns or management solutions have to be developed across the country. Indeed, sensitivity to patients' needs and wishes requires flexibility in the way services are provided:

- the needs of individuals vary;
- the needs of communities vary: some population groups experience more illness and premature death than others; some face particular difficulty in accessing services; and services in rural areas will be different from those in urban or suburban areas;
- services will be at different stages of development across the country, and priorities for development will vary accordingly.

The structures and processes of the NHS need to be responsive to these different needs and circumstances. Resource allocation and priority setting need to reflect local needs. Both the nature of these needs and the capacity of the NHS to respond to them change over time, and the NHS must retain the flexibility to adapt accordingly.

"You have to be open minded - working with others, exploring new possibilities and helping people to solve problems as they see them, rather than working from formal assessments."

Kathy Richardson, Team Member
Disability Resource Team, Chesterfield

Realising the Ambition: the Challenge

"...the aim must be...to provide the best service possible within the limits of the available resources."

The ambitions set out in this document build on the best of current practice. Extending this quality of care to the point where it becomes a reality for all patients, day in and day out, is a challenge indeed. Hard-pressed staff, working at full stretch to cope with increased emergency medical admissions, or juggling with competing calls on their time and energy, may well ask just how realistic and affordable such ambitions are, and what can be done in practice to begin to develop more responsive services. This Chapter therefore looks at the pressures on the NHS and the scope to respond to them.

Debates about whether the NHS can afford to respond to the expectations placed upon it are nothing new. As early as May 1953, less than five years after the founding of the NHS, a Committee of Enquiry (the Guillebaud Committee) considered the cost of the NHS. It addressed the question of what constituted an "adequate service", and suggested that:

> **"If the test of 'adequacy' were that the Service should be able to meet every demand which is justifiable on medical grounds, then the Service is clearly inadequate now, and very considerable additional expenditure (both capital and current) would be required to make it so."**[6]

The Committee went on to point out that any definition of adequacy would not be able to keep pace with advancing medical knowledge nor with the continual rise in the standards expected by the public and concluded:

> **"In the absence of an objective and attainable standard of adequacy, the aim must be, as in the field of education, to provide the best service possible within the limits of the available resources."**

Providing the best service possible within the limits of the available resources has always been the challenge for the NHS. But it has never prevented the NHS striving for – and achieving – ambitious results. The record speaks for itself. The Appendix summarises the scope and impact of the services the NHS has been able to provide. The past 50 years have seen people living longer and in better health, the development of primary care services that are the envy of the world, and a range of hospital provision that has far exceeded the expectations of its founders. All this has been achieved with a cost-effectiveness that commands international respect. No better model than the NHS has been found for adapting to change and development and making the best use of available resources to meet demand for health care.

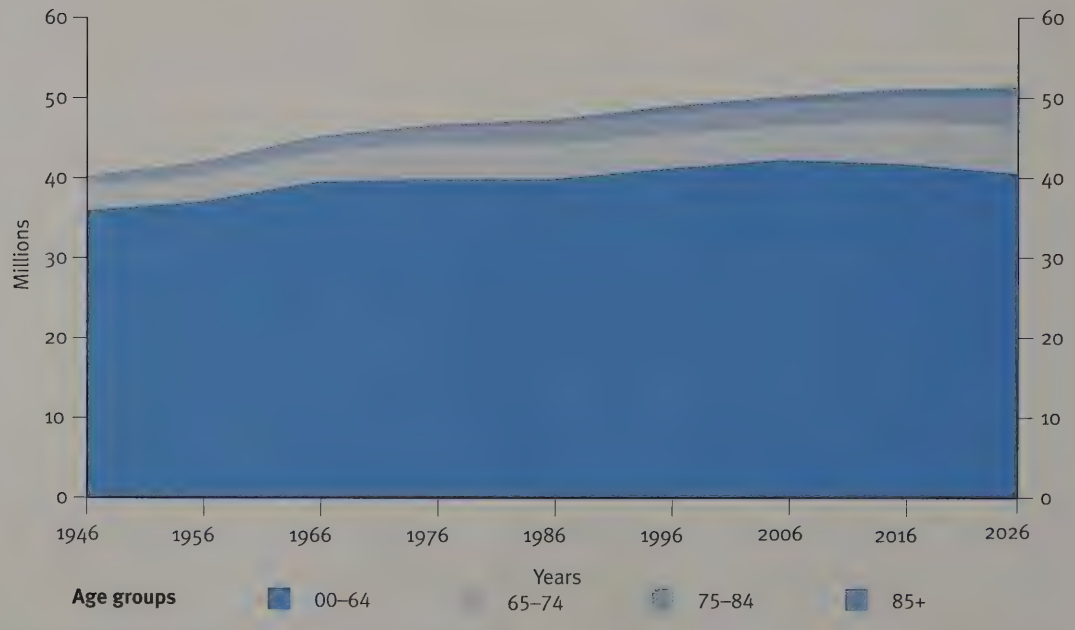
What of the pressures for the future? The factors which have played a large part in influencing health care spending in the recent past – population characteristics, public expectations, and medical advances – are likely to continue as the major driving forces into the 21st century. The Government believes that these pressures are manageable.

Demographic Change

Changes in the size and age structure of the population ("demographic change") inevitably affect demands on the NHS. The rapid rise in the numbers of elderly and very elderly people has been an important feature in the development of services in recent years. However, the evidence on future demographic pressures does not suggest an unmanageable growth in demand.

First, and most critically, the *rate* of increase in the numbers of very elderly people is now slowing down. The figures below show how the numbers of people in various age groups have changed over the past 50 years, and the forecasts for the future. Although numbers of 65–74 year olds will begin to increase more rapidly as we move into the next century, the next decade in particular will see lower demographic pressure than for many years. For example, in the ten years to 2006 (as in the decade following), the number of people over 85 is expected to increase by about 100,000, only one third of the growth in the last ten years.

Changing age composition of the population
England 1946 to 2026



Source: ONS population estimates to 1986. GAD 1994 based population projections 1996–2026.

Increase in number of people aged 85 and over
England 1946 to 2026

Period	Additional number of people aged 85 and over	Number of people aged 85 and over at the end of decade	% increase
1946–1956	70,000	240,000	41.2%
1956–1966	100,000	340,000	41.7%
1966–1976	119,000	459,000	35.0%
1976–1986	153,000	612,000	33.3%
1986–1996	302,000	914,000	49.3%
1996–2006	110,000	1,024,000	12.0%
2006–2016	100,000	1,124,000	9.8%
2016–2026	153,000	1,277,000	13.6%

While life expectancy has increased, research here and abroad on trends over the past 15–20 years suggests that the extra years of life have not been years of severe disability, but of mild to moderate health problems[7]. NHS spending per head on the elderly has risen no faster than spending on all age groups. There is continuing debate about future trends in morbidity and their implications for the demand for care, but it would be wrong to assume unmanageable pressures.

Public Expectations

The public has always expected high standards of the NHS, looking to it to guarantee safe and effective treatment and to respond to and offer new developments. As part of a general trend in society, expectations now go still wider, with users of health services quite legitimately wanting more say in how the NHS develops; which services are provided; and the standards of those services. Patients want more information about their disease, symptoms and prognosis, and to take a more active part in planning their treatment and care. The influence of patient interest groups is growing, both locally and nationally.

The Government welcomes this move towards the involvement of the users of the health service in their care. Through *The Patient's Charter* and the publication of information showing the performance of local hospitals and health authorities, more information is available for people on what they can expect from the NHS and social care services and how their local services are performing. With information and involvement goes responsibility. Having more information not only helps people have a greater say in the way health care is provided, it also helps them make more appropriate and responsible use of services and take greater responsibility for their own health.

Historically, the public's expectations of public services have risen in line with individual incomes. This can be expected to continue, although there is no indication that expectations will rise faster in relation to incomes than they have in the past. Better informed patients will not necessarily demand more resources, although they will wish to engage in dialogue with health service professionals and managers about what will deliver the best quality and outcomes for them.

Medical and Technical Advances

Scientific advances are often cited as an additional pressure on health care spending. While it is undoubtedly the case that the introduction of some new techniques or medicines requires increased resources, there are some that reduce the costs of improving health.

New drugs can be expensive, but may have the potential to reduce the need for hospital admission (for example, the use of preventive medication in asthma management), or allow safe earlier discharge (for example, as a result of modern antibiotics). Minimally invasive surgery may take longer to carry out than conventional surgery, but with the right preparation and support the patient recovers more quickly and spends less time in hospital. Some medical advances reduce the unit costs of providing particular treatments, and may also reduce the need for continuing the treatment altogether. For example, the discovery that acid-related ulcers may be healed by eliminating a gastric bacterium has reduced the need for long term drug therapy for peptic ulcers. Other advances make existing treatments available safely to a larger number of people as well as introducing new treatments for an ever wider range of conditions. Examples include improvements in anaesthetic gases and less invasive surgical techniques which have made surgery a safe and effective option for the more elderly and frail.

Medical advance has been a major driver of increased health care expenditure over the past few decades, but there is to date no evidence of an acceleration in the overall pressure on expenditure. In addition, there continues to be scope for funding desirable improvements in part by offsetting savings elsewhere, such as reducing expenditure on those treatments which are now recognised to be less clinically and cost-effective. For instance, the rate of growth in spending on medicines has been contained in recent years as a result of vigorous promotion of measures such as generic prescribing.

Managing the introduction of new technologies is a continuing challenge, but the NHS is becoming more effective in this, identifying and adopting those which will

bring real benefit while discouraging those which are less cost-effective. The health technology assessment programme aims to ensure that significant new medical advances are properly assessed before widespread uptake, and that specialist advice is available to help clinicians make best use of them.

The Government's Commitment

For its part, the Government is firm in its intention to continue providing the funding for the NHS to carry out its work. The NHS has grown to be the second largest public spending programme as successive Governments have reflected the priority which the public attaches to the health service in their decisions on its funding. As the economy has grown, NHS expenditure in England has risen on average by some 3% per annum in real terms since 1978/79.

The Government believes that the NHS should continue to share in a growing economy. As evidence of this belief it remains committed to real terms increases in NHS spending, year by year. The NHS itself has a clear responsibility to provide best value to the taxpayer. It must maintain its commitment to improved performance by ensuring that people working in the service have access to timely information about effectiveness, quality and outcomes; the incentive systems, both economic and professional, must promote good performance, and all who work in the NHS must constantly strive to improve the standards of patient service to the level of the best.

Setting Priorities

Ambitious plans take time and resources to achieve, and difficult choices – about service and patient priorities – sometimes have to be made. The capacity to shift resources between different parts of the NHS programme to meet changing needs will be a key issue for the future, but such changes must be carried through with public support. People working in the NHS face difficult decisions on a day to day basis and it is inevitable that many of these will be much more explicit than before. The management reforms have gradually allowed the NHS to be much more open and systematic about setting priorities between competing demands, and this approach will continue as the NHS seeks to deliver high-quality, cost-effective treatment from the resources available.

The Government noted in its response to the Health Select Committee's report on "Priority Setting in the NHS: Purchasing"[8], that priorities in the NHS are set at three levels:

- ministers, advised by the NHS Executive, set out a framework of national priorities and targets for improvement;
- health authorities and GP fundholders assess the needs of the people they serve and decide what treatments and services are required to meet those needs. This process should be informed by proper consultation with the public;
- individual clinicians decide the most clinically appropriate treatment and clinical priority for each patient, based on their assessment of that patient's needs.

In addition there are clearly-defined values to guide local decision-making:

- equity – improving the health of the population as a whole and reducing variations in health status by targeting resources where needs are greatest;
- efficiency – providing patients with treatment and care which is both clinically effective and a good use of taxpayers' money;
- responsiveness – meeting the needs of individual patients and ensuring that the NHS changes as those needs change, and as medical knowledge advances.

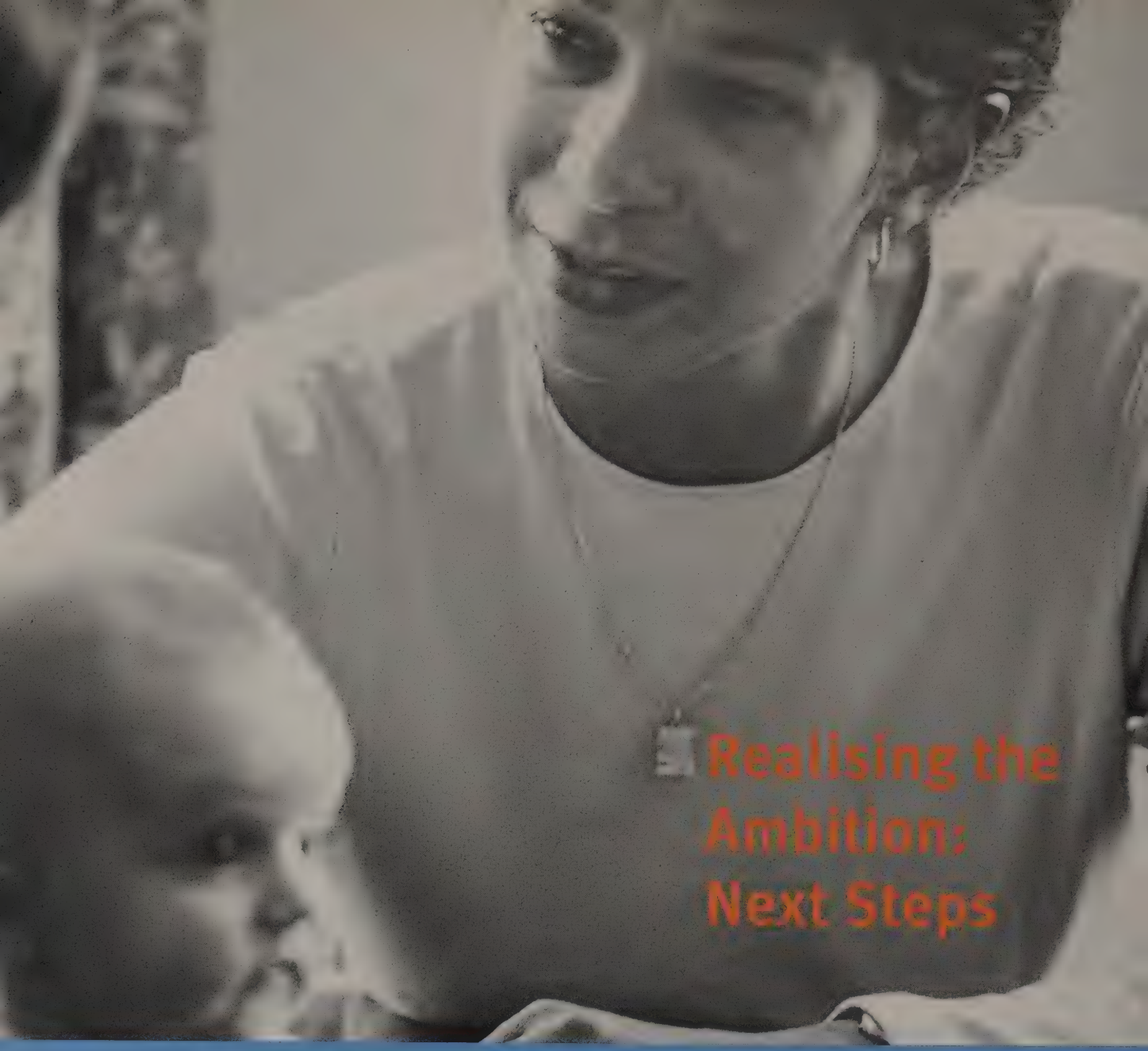
These principles can, of course, only provide a guide to local decision-making. They cannot be quantified or converted into a universal formula to substitute for informed human judgement operating at local level and in full knowledge of the circumstances. No one principle has overriding importance. They need to be considered together, balancing the interests of individual patients and the community as a whole.

Some commentators have argued that the Government should prescribe at national level what treatments the NHS should provide. The Government does not believe this would be right. No such list of treatments could ever hope to accommodate the range and complexity of the different cases which individual clinicians face all the time. There would be a real risk of taking decisions out of the hands of the clinicians treating patients and into the province of others who possess neither the experience of caring for patients nor the expertise to make such decisions.

Patients, clinicians and health authorities all want clinical decisions to take account of research information about the effectiveness of treatment. The Government has made it clear that there should be no clinically effective treatments which a health authority decides as a matter of principle should never be provided. Even where the effectiveness of a particular procedure is not in general judged to be high, it might be both effective and appropriate in certain circumstances for an individual patient. To deny clinical access to the availability of such treatments would fly in the face of the principles outlined above.

The Challenge

The Government remains firmly committed to this overall approach and expects the NHS Executive to develop its work with health authorities, NHS Trusts and the health care professions to establish a more systematic means of setting priorities at every level of the service. Achieving best value from the resources available and building on the progress set out in the Appendix represents a huge challenge for the NHS. It is a challenge which must be met to ensure that our ambitions for the future are fulfilled.



Realising the Ambition: Next Steps

Objectives:

- *a well-informed public*
- *a seamless service, working across boundaries*
- *knowledge-based decision-making*
- *a highly trained and skilled workforce*
- *a responsive service, sensitive to differing needs*

Responsibility for managing the NHS rests firmly with the NHS Executive, local health authorities and NHS Trusts. The Government does not wish to usurp this function – the purpose of this White Paper is to provide a clear framework within which these bodies carry out their responsibilities. Each management team needs to ensure that its plans for the future address the strategic objectives identified in Chapter Two. The detail of implementation will differ in each locality, but the objectives are clear and they apply with equal force in different parts of the country.

In support of these five strategic objectives, and to improve health and health care, the Government believes that there are some specific underpinning issues which need to be addressed if our ambitions for the future of the NHS are to be delivered.

Primary Care

The first of these concerns the development of primary care. The increasing range of services available in NHS primary care, together with the improving facilities in which they are delivered, represent a major development of NHS services. GPs are in a unique position to assess the needs of their patients and to act as their advocate in the rest of the NHS. Through GP fundholding and involvement in commissioning they have also strengthened their influence over the development of other NHS services. In addition, there are opportunities and challenges facing dentists, pharmacists and optometrists. Nurses, health visitors and therapists play an important and increasing role in primary care. In all these fields there is a drive towards more effective and more cost-effective use of professional skills.

The White Paper on the future of primary care published recently sets out the Government's plans for legislative change necessary to take these developments forward.[9] A further document at the end of this year will set out a programme of measures which do not require primary legislation. The primary care Bill, announced in the Queen's Speech on 23 October this year, will make it easier for GPs and health authorities to remedy weaknesses in the primary care system. It will also give GPs, dentists, pharmacists and optometrists, and other members of the primary health care team, new opportunities to develop their practice to the benefit of their patients. These proposals have been developed following an extensive programme to listen to the views of professional groups, patients, the public and NHS managers. They command widespread support in the field and they represent an important further step in the development of NHS primary care.

The Government now intends to build on the success of the approach to primary care development by launching programmes of work designed to address three further key issues for the NHS as a whole. The process will be similar to that used to develop primary care. There will be no expert committee working in isolation. The work will be led by named individuals who will be charged with seeking views across and beyond the NHS and distilling the views, experience, and insights of all of those who put suggestions to them. The emphasis will be on:

- refining and improving existing policies;
- ensuring that these policies fit within a coherent strategy;
- overcoming practical obstacles to progress.

The aim will be to build on existing policies and commitments, and to avoid delaying in the meantime necessary planning and implementation work in these and other areas; indeed, the development priorities set out in the annual Priorities and Planning Guidance for the NHS[10] all need to be pursued actively in order to improve the services to patients in the immediate future as well as over the longer-term.

Information

Almost all observers agree that the NHS needs to improve the way it handles information. It needs:

- to provide information to patients and the public so they can make informed choices about their own lives, know what action to take to help themselves, know when and how to seek help, and so they can take part in decisions and choices about care and treatment;
- to provide professionals, at the point of clinical decision, with relevant information about the latest clinical knowledge, research findings, effective practice, and health outcomes;
- to ensure that confidentiality of patient information is maintained while ensuring that such information is available as necessary to clinicians responsible for the care of individual patients, wherever possible avoiding the need for patients to respond several times to the same set of questions;
- to provide information about services and resources to support research, audit and the efficient running of the service.

The delivery of these objectives requires an effective and efficient information and communications system. Current policy includes the establishment of the NHS network, the introduction of a single NHS number and the development of a common language to describe clinical activity. But progress in the NHS to deliver the necessary information infrastructure must be quicker if it is to achieve these objectives. Work is also in progress to help improve the capacity of the NHS to provide high-quality information for patients and the public about services and treatment options and outcomes. John Horam MP, the Parliamentary Under Secretary of State for Health, will be examining progress in this field. He will be joined by Frank Burns, the Chief Executive of Wirral Hospital Trust, and the NHS Executive's Director of Human and Corporate Resources, Ken Jarrold. They will be seeking views both from within the NHS and from interested parties outside.

Professional Development

The developments envisaged in this White Paper have implications for the skilled professionals working in the NHS. Modern health care relies increasingly on team work: the development of multi-professional teams, working not only in hospitals and primary care settings, but across the traditional boundaries of health and social care, is a key priority. The objectives of a well-informed public and a responsive service also mean that the relationship between patients and professionals is changing. Professionals themselves need training and support if they are to help patients become partners in their own care.

Professional education, training and development relies on a partnership between Government, NHS employers, the health professions, the statutory and regulatory bodies, the Royal Colleges and the universities. The aim is to develop and implement policies which support properly structured education and training at pre-qualifying/basic and post-qualifying/higher levels and throughout the professional career, and which ensure there are sufficient professionally qualified and trained staff to enable the NHS to meet its strategic objectives. To achieve this the NHS and the main professional bodies must continue to develop a shared view of likely future developments in clinical practice and the provision of services.

The further work in this area will:

- consider existing policies for professional development, and assess the extent to which they support the strategic objectives of the NHS;
- consider how best to encourage multi-professional working and effective team working;

- consider how the existing partnerships might be developed to ensure high standards of basic, higher and continuing education, reflecting changing patterns of service;
- consider the deployment of NHS education and training budgets, drawing particularly on the development priorities of employers and the concerns of the professions.

This work will be taken forward by Professor Howard Newby, the Vice-Chancellor of Southampton University, working closely with the Chief Professional Officers in the Department of Health and Barbara Stocking, the NHS Executive's Director of the Anglia and Oxford region.

Managing for Quality

Securing the highest quality of care for patients is one of the fundamental aims of the NHS. Working together to achieve that objective is the responsibility of everyone in the NHS, using all of the resources available to them to maximum effect. This should be the focus of all discussions about what the NHS does and how it goes about it.

In this context the term quality is used in the widest sense, embracing the values of equity, efficiency and responsiveness defined in Chapter Three. It encompasses:

- the effectiveness of treatment, in terms of the outcome for the patient;
- the skill, care and continuity with which the service is delivered;
- the accessibility of the service, in terms of distance, time, physical access, language and understanding;
- the delivery of the service, covering the physical environment of care, and the courtesy and efficiency of the administrative arrangements.

Underpinning this definition of quality is a commitment to using resources to best effect and getting it right first time.

Whatever the setting of care – a large hospital or a small family practice – quality in this wider sense can only be achieved through systematic setting of standards, careful scrutiny of performance, and effective management including action to make improvements if standards are not met. Ultimately, it is those who provide the service direct to patients who determine the quality of care, and they have a special role in

developing quality standards, assuring quality and auditing their own performance. People working in health authorities also have an important contribution to make, in creating the conditions and providing the stimulus for a quality service.

Quality in this sense is not merely an aspiration, but the very essence of the performance of the NHS. It should be the driving consideration in clinical decision-making and in priority setting, and the basis on which the NHS manages and measures its performance. It is a matter which lies at the heart of the management process in every health authority, NHS Trust and family practice. It needs to be addressed by clinicians and managers, working together to establish a common language and shared objectives.

Further work to ensure that quality is always central to the management and performance of the NHS needs to address:

- how the measurement of quality and outcome across a range of clinical treatments and methods of service provision can be improved;
- how to use patients' experiences to monitor and improve the quality of care, particularly in relation to accessibility, continuity and co-ordination;
- whether current work on using clinical effectiveness data to improve clinical practice meets the needs of clinicians, managers and patients;
- how greater emphasis can be given to considerations of quality and outcome in decisions taken on priorities and the commissioning of care;
- how measures of health outcome can become central to assessing the peformance of health authorities and NHS Trusts.

This work will be led by the Chief Medical and the Chief Nursing Officers of the Department of Health and Chris Howgrave-Graham, the Chief Executive of Coventry Health Authority.

Concluding Statement

Ambitious plans take time to achieve. Ours will be no exception. The milestones we set need to be demanding, but realistic.

Sometimes, looking to the future can seem like a luxury, when faced with the pressures of the moment. But having a clear sense of direction helps to inform the decisions of today in a way which enables the achievement of longer term ambitions.

The Government is committed to build on the founding principles of the National Health Service and to support its development in a way that allows these ambitions to be realised. This White Paper has set out the strategic objectives that need to guide progress over the next few years. Throughout its history the NHS has found ways of accommodating the pressures on it, and there is no reason to doubt its ability to continue to do so.

We have asked the management team of each health authority, NHS Trust, and those in primary care, to plan their own contribution to achieving our ambitions. But we have also identified three programmes of work where national leadership is required. We know that the solutions require the insight and involvement of the health care professions, patients, the public and NHS management and our approach will encourage their participation.

Our plans are ambitious; but every step we take towards them means we better meet the needs of patients and the public.

Appendix

The Record of the NHS

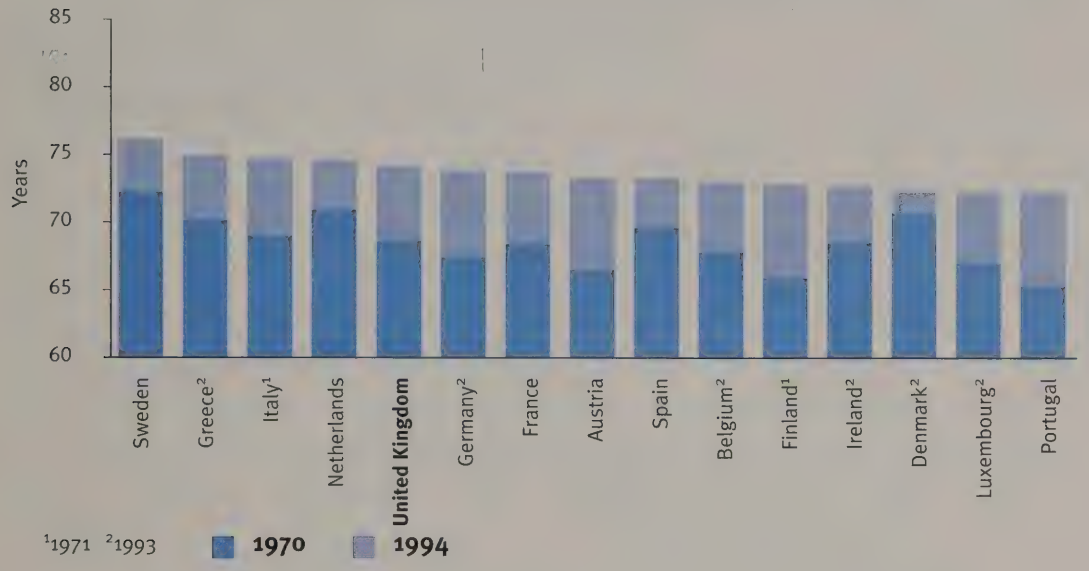
It is recognised internationally that the National Health Service "is a remarkably cost-effective institution"[11]. It achieves health outcomes comparable to those achieved in other countries with similar or higher incomes and at a cost, in terms of share of national income, that is significantly lower than in most such countries.

The charts in this Appendix depict graphically this record of achievement and show how far the NHS has come during the last 50 years; a reflection of the skill and dedication of all its staff and of the resources which successive Governments have devoted to it. As a result the NHS has retained the allegiance of the population to an extent matched by very few other national health services; only about 12% of the population have some form of private health insurance compared with a third of the population in Australia, 40% in New Zealand and over 60% in Canada.

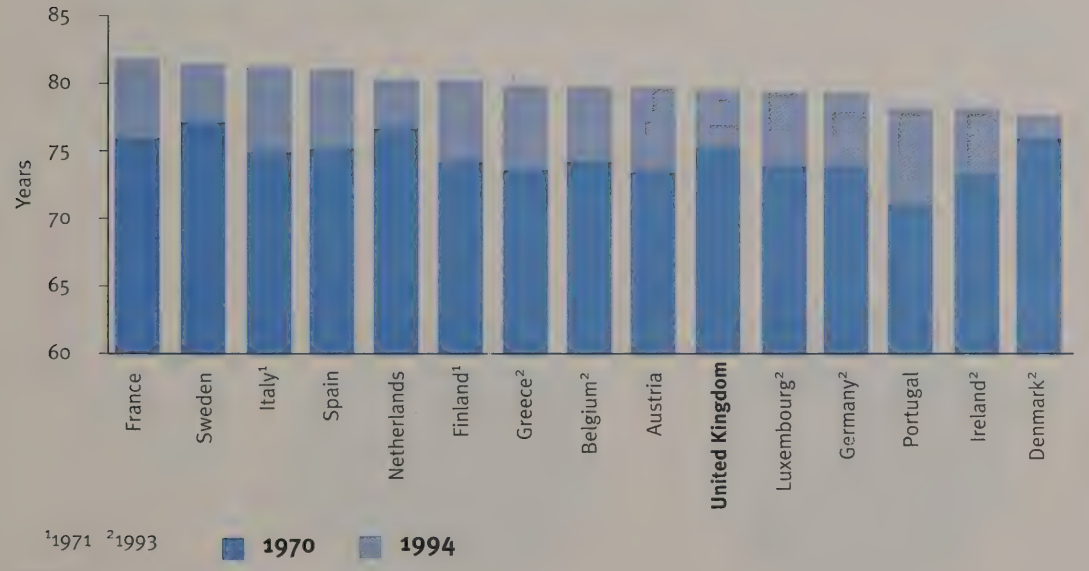
Public Health (Charts 1–5)
The NHS has played a major role in improving the health of the population. Since the NHS was founded, life expectancy has increased by 7.6 years for men and 7.8 years for women, or roughly one and a half years a decade. Over the same period, infant mortality rates have fallen by more than 80% (from 40 per 1,000 live births to 6 per 1,000).

These trends are broadly comparable with those in other West European countries. In terms of life expectancy and infant mortality rates the health of our population is similar to that of other countries in the European Union (Charts 1–3).

1 Male life expectancy in the European Union
1970 and 1994

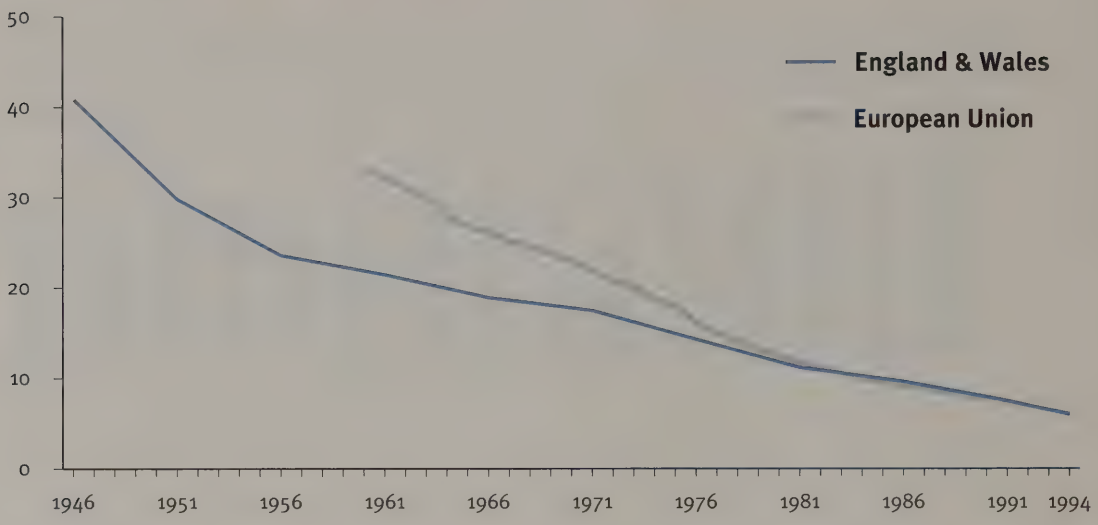


2 Female life expectancy in the European Union
1970 and 1994



Source: OECD

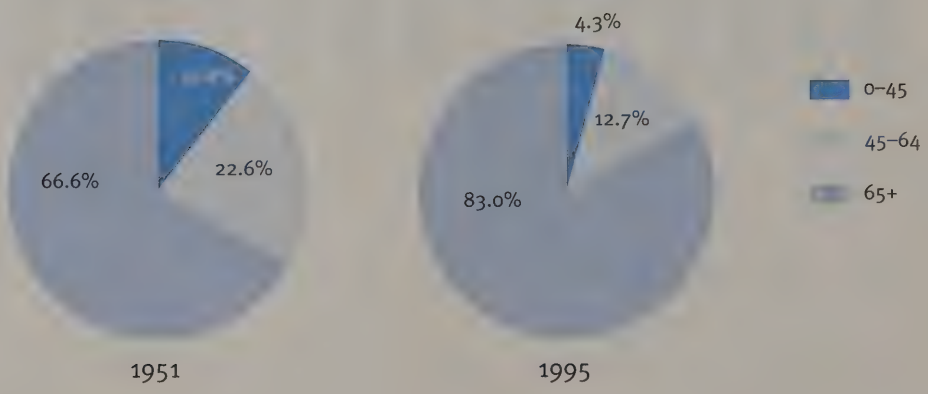
3 Infant mortality rates per 1,000 live births
1946 to 1994



Sources: ONS and OECD

The general improvement in life expectancy has been accompanied by a major reduction in the inequality in the age at which people die. Forty years ago a third of annual deaths occurred before the age of 65. Today the proportion is one-sixth (Chart 4).

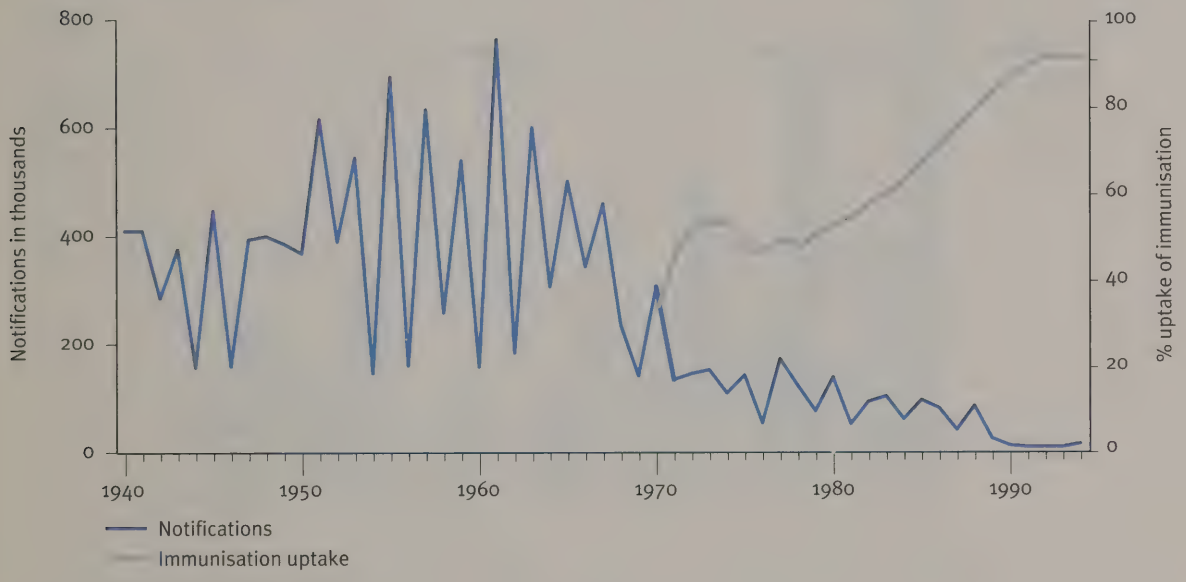
4 Reductions in inequalities of ages of death
England & Wales 1951 and 1995



Source: ONS

The NHS has contributed to major changes in the incidence of particular diseases since 1940. Chart 5 shows the relationship between the uptake of immunisation against measles, and the number of notifications of the disease.

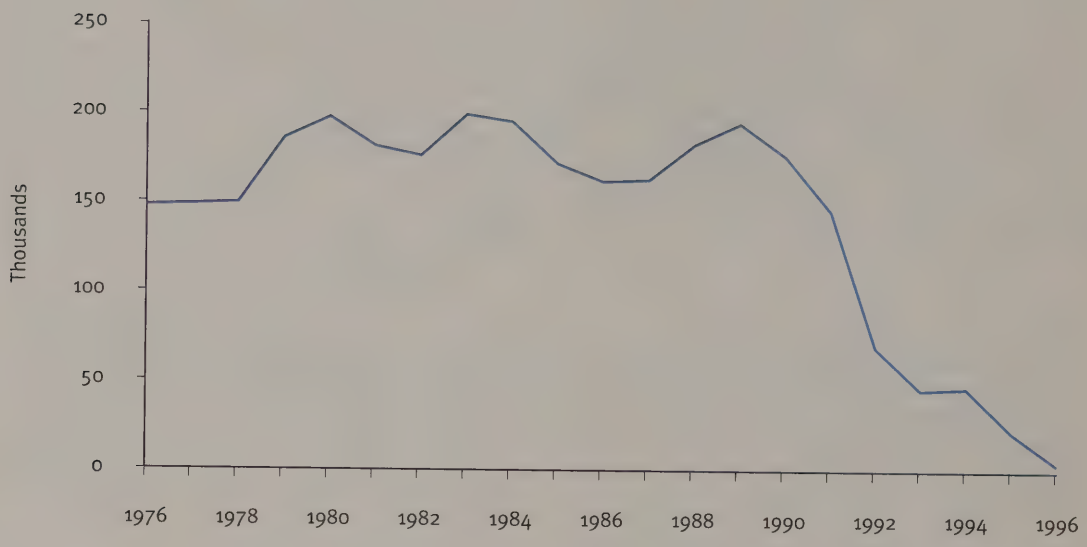
5 Measles: notifications and immunisation
England 1940 to 1994



Source: ONS & DH SD2B

Hospital and Community Health Services (Charts 6–10)
The most criticised aspect of the NHS over the last 40 years has been the length of waiting times. Recent years have seen a dramatic fall in the number of people waiting for more than one year for elective admission (Chart 6). This decline can be attributed to better management, the hard work of staff and a large growth in hospital activity.

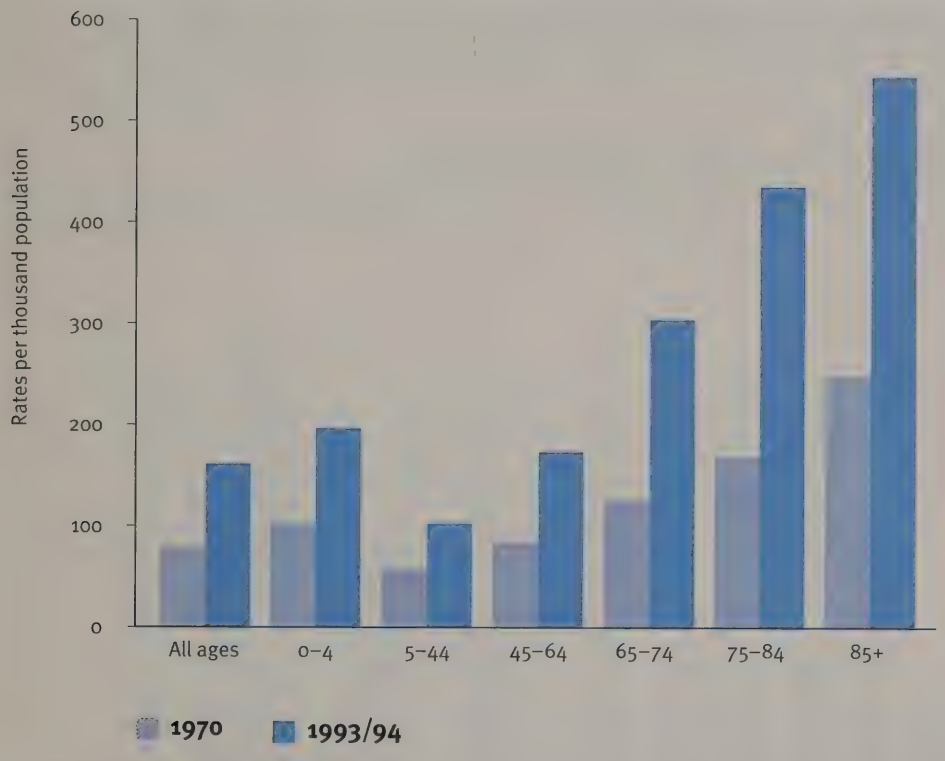
6 Numbers waiting more than 1 year for elective admission
England 1976 to 1996



Source: DH FPA-PA

The total number of hospital admissions, including day cases, has increased threefold since 1949. Adjusting for the increase in population, hospital admission rates per 1,000 population have more than doubled since 1970. The increase in treatment rates has benefited all age groups but has been particularly pronounced for older people (Chart 7). For example, for people aged 85 and over, the last 25 years have seen an increase in hospital admission rates from 250 per 1,000 to over 500 per 1,000.

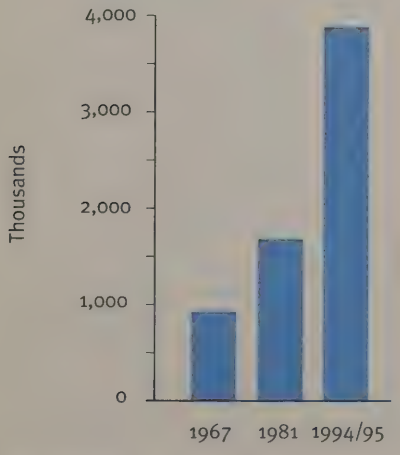
7 General and acute sector: hospital in-patient admission rates
(ordinary admissions plus day cases) – England 1970 and 1993/94



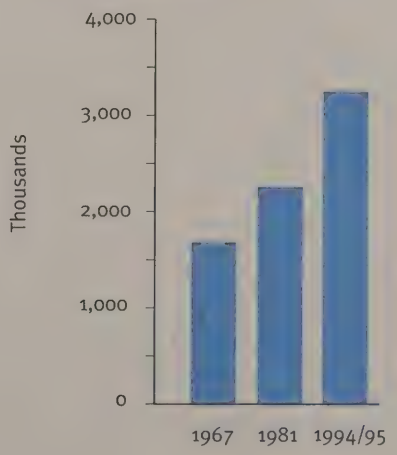
Source: DH SD2 HES

The increase in hospital in-patient activity reflects a huge growth in elective surgery and a very substantial increase in emergency admissions (Chart 8). Elective surgery has more than doubled over the last 14 years.

8 Elective surgery
(general & acute sector, NHS hospitals, England) 1967 to 1994/95



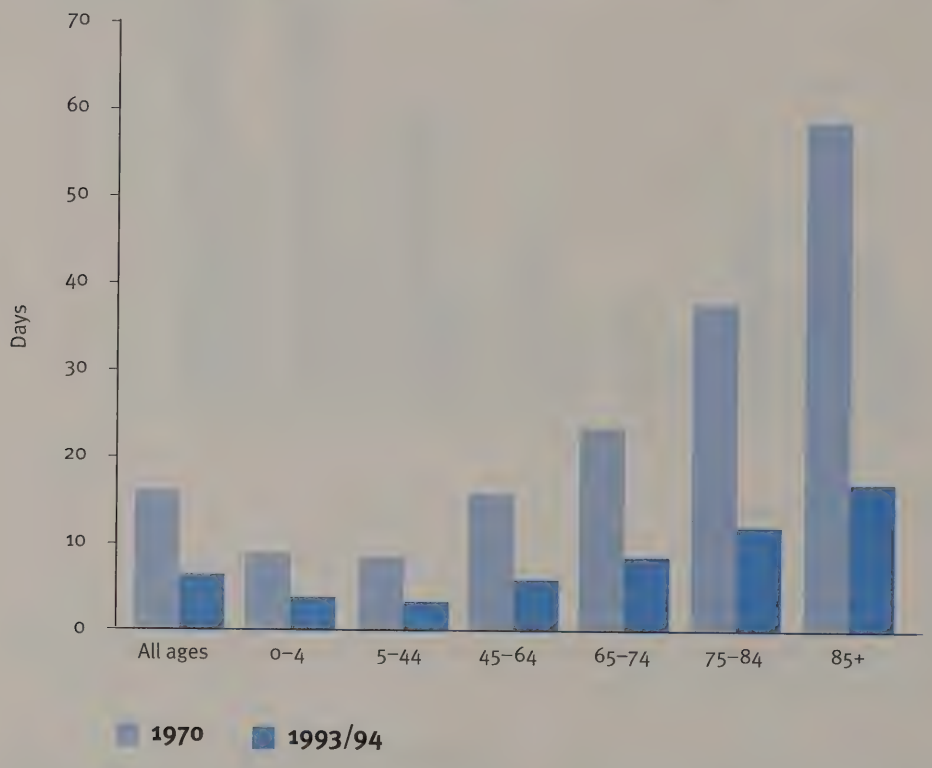
Emergency admissions
(general & acute sector, NHS hospitals, England) 1967 to 1994/95



Source: DH SD2 HES

The growth in hospital in-patient activity has been accompanied by an even more dramatic decline in the length of hospital stays for in-patients. Excluding day cases, average lengths of stay have fallen by almost 60% since 1970 (Chart 9). In consequence, the total number of hospital beds has been falling for 30 years.

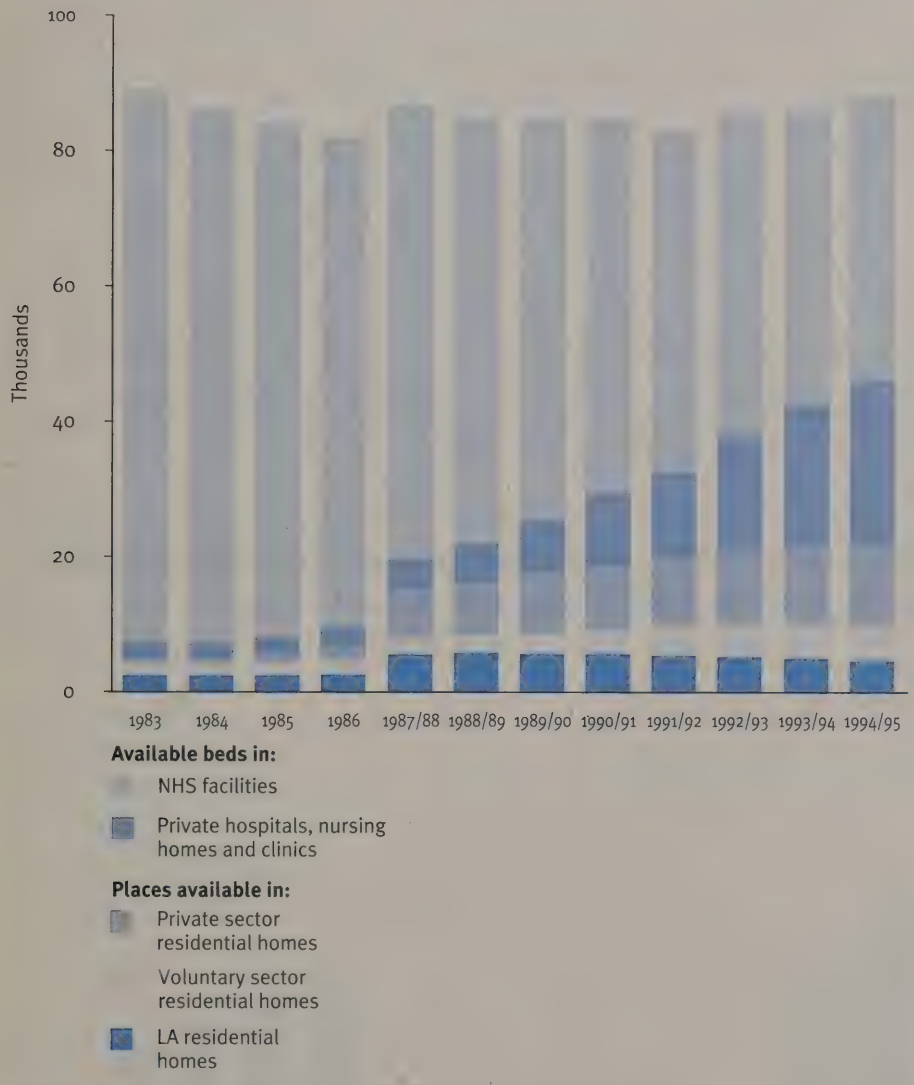
9 General and acute sector: hospital average length of stay
(in-patients excluding day cases) – England 1970 and 1993/94



Source: DH SD2 HES

There have been equally dramatic shifts in service provision. For example, the last ten years have seen a major shift in residential services for people with a mental illness, away from the large asylums to a much more varied spectrum of community services, including group homes, 24 hour nursed NHS accommodation and residential care homes (Chart 10).

10 Mental illness: places in residential homes and beds in hospitals and nursing homes
England 1983 to 1994/95



NB: Elderly mentally ill places in residential care are not included prior to 1987/88.

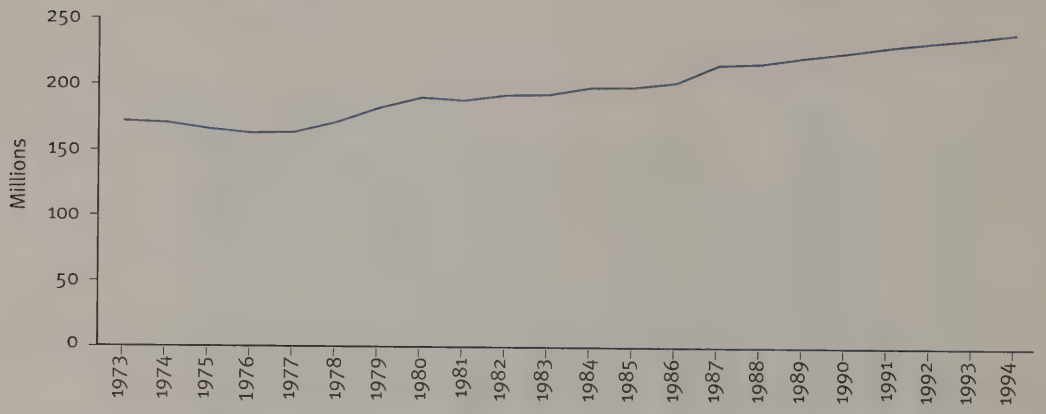
Source: DH SD2 C

Family Health Services (Charts 11–15)

The increase in hospital and community health service activity has been paralleled by the growth in primary care services. For example:

- The number of GP consultations has risen by nearly 40% since 1971 (Chart 11).

11 Estimated number[1] of GP consultations (three-year running average[2])
England 1973 to 1994

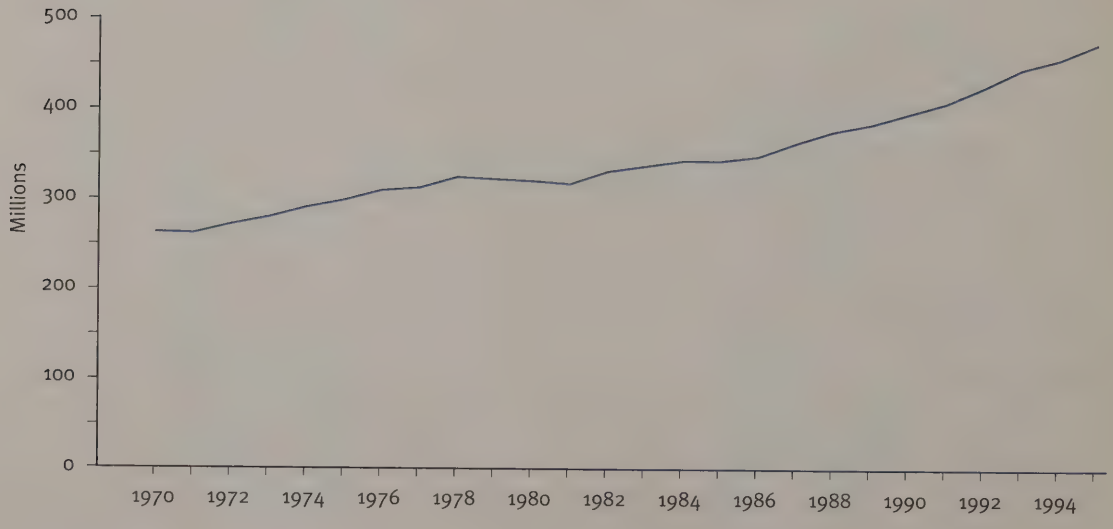


1 Estimates are based on GP consultation rates per head for Great Britain (1971 England and Wales), grossed up by England population figures.
2 The estimates for each year have relatively large standard errors and so a three year moving average has been charted rather than the actual figures for each year, ie the figure for 1994 is the running average of 1992, 1993, 1994.

Source: GHS Analysis by SD2D

- The number of prescriptions has nearly doubled since 1970, with a particularly rapid increase over the last ten years (Chart 12).

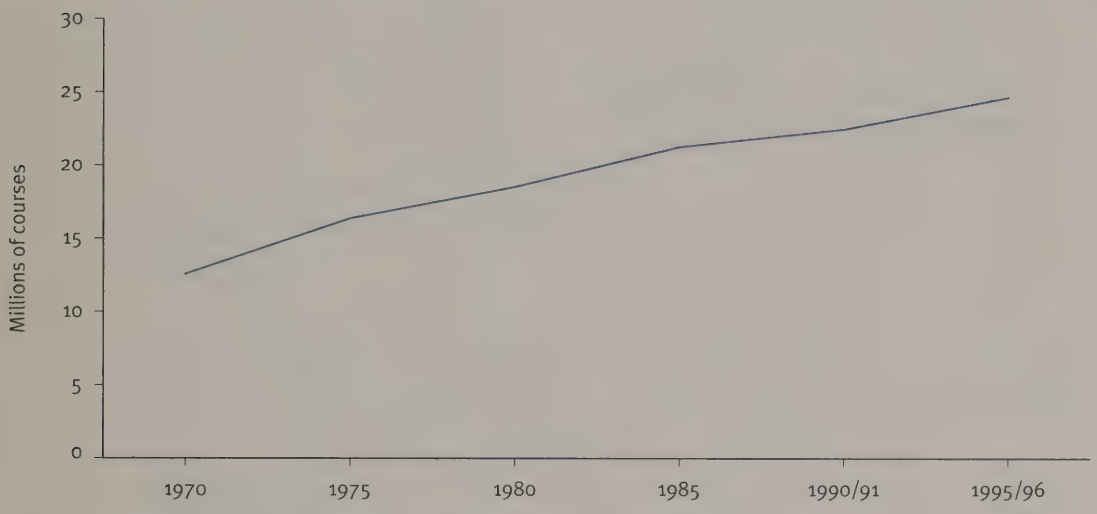
12 Number of prescriptions
England 1970 to 1995



Source: DH SD1E
NB Data prior to 1991 are based on fees and cover prescriptions dispensed.
Data from 1991 are based on items and have a slightly different coverage.

- The number of adult dental treatments has roughly doubled over a similar period (Chart 13).

13 Courses of adult GDS treatment
England 1970 to 1995/96

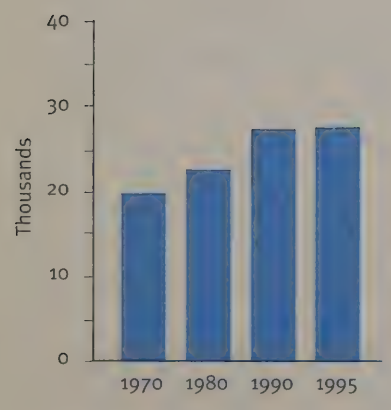


NB The figures from 1970 to 1985 are for calendar years, from 1986/87 onwards the figures are for financial years

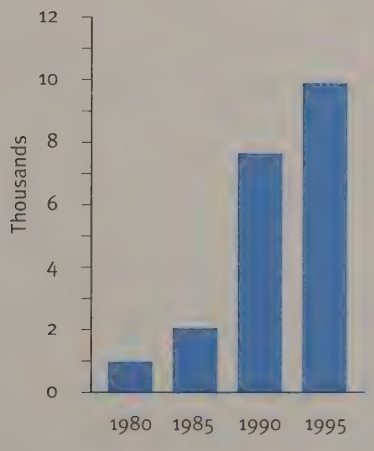
Source: DH SD1B

The increases in primary care services have been made possible by major increases in professional staff. The number of GPs has risen by 40% over the last 25 years (Chart 14). The number of practice nurses has increased much more rapidly over the last 15 years (Chart 15).

14 Number of GPs
England 1970 to 1995



15 Practice Nurses
England, Whole Time Equivalent
1980 to 1995

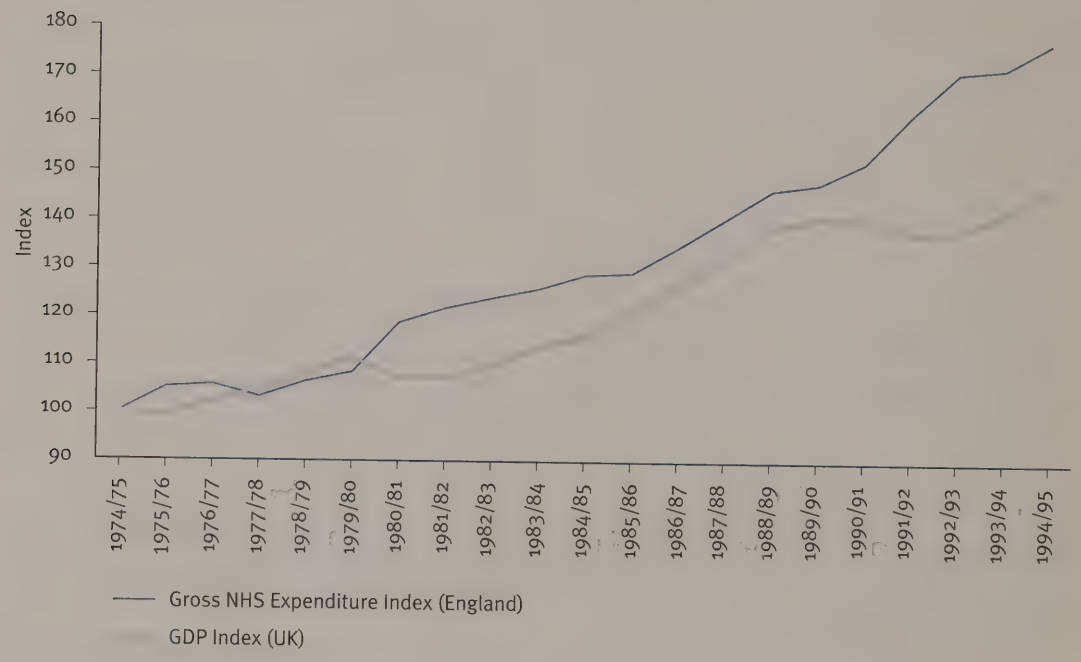


Source: DH STATS (W)

Expenditure and Efficiency (Charts 16–17)

Underpinning the growth in health service activity has been a steady increase in expenditure on the NHS. For example, over the last 20 years, expenditure has risen faster than total national income (Chart 16). Over the same period the share of NHS expenditure in GDP has risen from 4.8% to 5.8%.

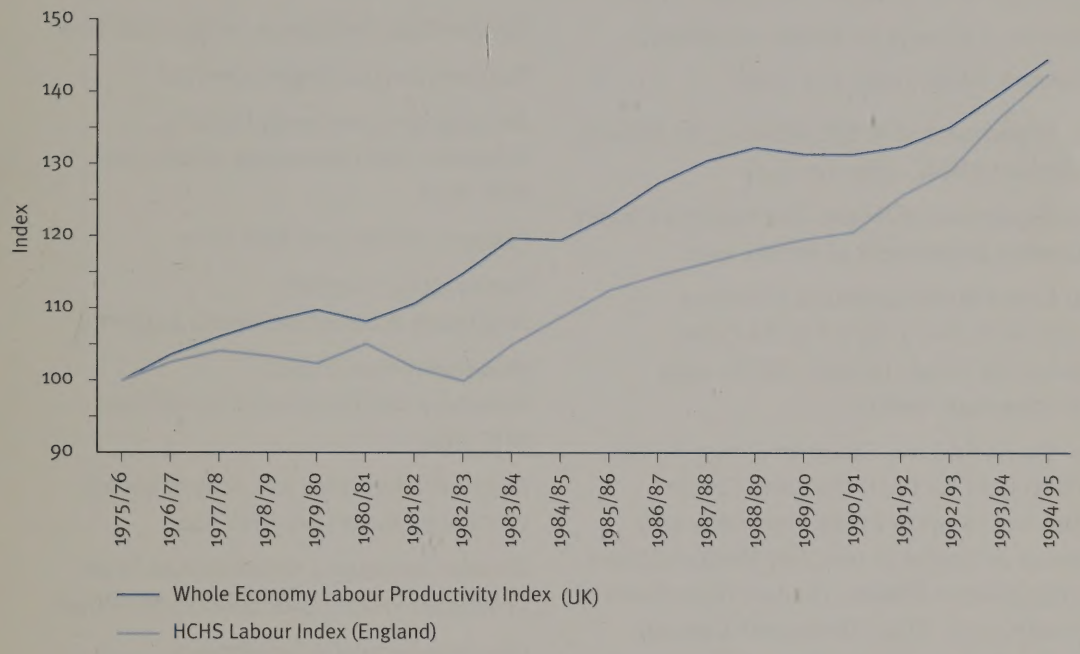
16 GDP and Gross NHS Expenditure Index
1974/75 to 1994/95



Source: HMT and DH FPA-PES

The growth of services is also a reflection of improvements in efficiency and a tribute to the increased productivity of NHS staff. Over the last 20 years, labour productivity across the hospital and community health service as a whole has risen by over 40%, broadly in line with trends in labour productivity across the whole economy (Chart 17).

17 HCHS and Whole Economy Labour Productivity Index
1975/76 to 1994/95



Source: DH EOR and ONS DMBE

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